

**Patient Name: William Bevan**

*Patient Refused  
To sign  
Contract*

***Welcome! Thank you for choosing***

**ProMedica Skilled Nursing and  
Rehabilitation (Wheaton)**

**Here's What We Will Discuss:**

- 1) Maryland Standard Admission Agreement – Resident's Agent Financial Agreement
- 2) Patient Information Handbook
- 3) Center Supplement
- 4) Voluntary Arbitration Agreement

Resident's or your approval), we will arrange for the services to be provided by an outside provider, or we will arrange for the Resident's transfer to the hospital or other health care providers.

Personal Services

C. We will provide the Resident with room and board, housekeeping services, recreational and social programs, and personal care.

D. We will provide the Resident with a reasonable amount of storage space for the Resident's personal belongings.

E. At the Resident's or your request, we will maintain the Resident's personal funds and will comply with the laws and regulations relating to our management of the Resident's funds. See Exhibit 5.

3. Paying for The Resident's Care.

A. Who Can be Required to Pay for the Resident's Care.

Only the Resident and the Resident's insurers can be required to pay for the Resident's care. You cannot be required to pay for the Resident's care from your own funds, unless you knowingly and voluntarily agree to pay for the cost of the Resident's care with your own funds.<sup>1</sup>

By signing this Agreement, you and the Resident agree to pay for care and services provided to the Resident with the Resident's income, funds and assets. (By signing this Agreement, you intend to bind the Resident to all obligations of this Agreement, including payment for care and services.) If you fail to pay a Facility bill, we may request a court to order such payment. You understand you may not use the assets or income of the Resident for any purpose that

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<sup>1</sup> Whenever the phrase "you will be charged", "you pay", or "you agree to pay" are used in this Agreement, it shall be subject to the qualifications of this paragraph.

You agree to pay either directly or through a third-party payor for all items and services provided to the Resident by the Facility. You request that the Facility send the bills to:

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B. Private Pay Residents.

The items and services included in our daily rate of \_\_\_\_\_ which include basic room, board and general nursing care as required by the Resident's medical condition are listed in Exhibit 2. Payment for items and services that are included in the daily rate is payable one month in advance and due on the first of each month. You agree to make timely payments.

You understand and agree that the Resident will be charged separately for additional items and services which the Resident or you (or the Resident's physician, with the Resident's or your approval) request and which are not included in our daily rates such as special nursing care, special equipment, pharmacy charges, laboratory charges and additional services such as telephone expenses, clothing, beauty and barber services and newspapers. A list of many of the ordinary items and services for which the Resident may be charged is at Exhibit 2. If the Resident, or you, or the Resident's physician (with the Resident's or your approval) request items or services other than those listed in Exhibit 2, you will be notified of the cost. Payment for these additional items and services is due within thirty (30) days after the Resident or you (or the Resident's physician with the Resident's or your approval) have requested them, and the Resident has received and been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment, you or the Resident have the right to ask us for an itemized statement that briefly but clearly describes each item and service, the amount charged for it, and the identity of the payor billed for the service.

you and the Resident will be notified of the Facility's intention to discharge the Resident for non-payment. You agree to continue to pay the Facility's prevailing daily charges until the date of the Resident's departure.

If there is any dispute about whether the Resident should be discharged, the notice and other requirements in Section 4.F. apply. If transfer or discharge becomes necessary because you or someone else abused the Resident's funds, the Facility will request that the Attorney General investigate which may result in prosecution.

If you believe that you may need to apply for Medical Assistance later for the Resident, you may want to find out now if the Resident is "medically eligible" for nursing home payment by Medicaid. (This is not, however, the same as applying for Medical Assistance benefits.) See Exhibit 3B. [The Exhibit is written in terms of the Resident.]

#### C. Medicare Residents

We participate in the Medicare Program. Medicare may pay for some or all of the Resident's nursing home care. For information on Medicare, see Exhibit 3A. [The Exhibit is written in terms of the Resident.] If the Resident is eligible for Medicare, you have the right to have claims for the Resident's nursing home care submitted to Medicare. You understand and agree to pay the Facility for amounts not covered by Medicare, including the co-payment which Medicare requires for most covered services, currently

Service Dates: 2023: \$200.00, which Medicare changes yearly. You also understand that some items and services offered by the Facility are not covered by Medicare and if you want (on behalf of the Resident) or the Resident wants any of these items or services, you agree to pay for them. (A list of the items and services not covered by Medicare and charges for them are at Exhibit 4.) If the Resident also participates in Medicare, Part B, for physical, occupational, or speech therapy or other billable charges which are

If you or the Resident would like your own copy, the Facility will provide one.

Some of the items and services that we offer are not covered by Medicaid. If you or the Resident want any items or services which are not covered by Medicaid to be provided to the Resident, you will have to pay for them. A list of the items and services not covered by Medicaid and the charges for them are at Exhibit 4. Payment for items and services that are not covered by Medicaid is due after the Resident, or the Resident's physician with your, or the Resident's approval, have requested them and the Resident has received them and you have been billed for them. Within ninety (90) days of the Resident receiving an item or service, or within thirty (30) days of payment, you or the Resident have the right to ask us for an itemized statement that briefly but clearly describes each item or service, the amount charged for it, and the identity of the payor billed for the service.

You understand that non-payment of items and services not covered by Medicaid may result in a discharge action for non-payment of bills. If all of the Resident's personal needs have been met, you understand that money in the Resident's personal funds account may be needed to pay for items and services not covered by Medicaid which were requested by you or the Resident (or the Resident's physician with the Resident's, or your approval) and are provided by the Facility.

E. Increases in Charges and Fees.

Any time we increase a fee or charge for an item or service or add a new item or service, we will provide you and the Resident with forty-five (45) days advance written notice.

H. Limitations of Liability.

The Facility is obligated to take reasonable precautions to provide the Resident and the Resident's personal belongings with security, including providing a reasonable amount of secured space for the Resident's belongings. The Facility, however, cannot be responsible for any loss or damage to the Resident's valuables or money that is not delivered into the custody of the Facility Administrator or his/her designee, unless that loss or damage is caused by the negligent or willful action of the Facility staff. The Facility's Policies and Procedures concerning the Resident's personal funds and the Resident's personal property are at Exhibit 5.

If, in spite of the Facility's best efforts, there is loss or damage to property, or injury or death to persons, which is mutually agreed to be or determined by an appropriate third party to be caused solely by the Resident, you agree to be responsible for the damage, injury, or death to the extent of the Resident's income, funds and assets. This responsibility includes payment for damages and all costs including reasonable attorneys' fees required to defend a claim resulting from such damage.

In addition, although the Resident has the right to make the Resident's own health care decisions, including the right to refuse treatment, you accept responsibility to the extent of the Resident's income, funds and assets for any consequences resulting from the Resident's refusal to accept nursing or medical treatment or service considered by the Resident's physicians to be necessary for the Resident's care.

Program, are responsible for the doctor's payment. If the Resident does not have a doctor, the Resident or the Resident's health care representative may choose one from the list of physicians who practice here. This list is attached as Exhibit 6. If the Resident or the Resident's health care representative is unable to choose a doctor, we will assign one to the Resident from this list. In case the Resident's doctor is not available when needed, our Medical Director, or designee, will take care of the Resident until the Resident's doctor is available.

Some services the Resident may require are available through outside providers. Some available outside providers and whether the Facility has a shared ownership interest with the Provider are at Exhibit 7.

C. Personal Property and Financial Affairs.

The Resident has certain rights relating to the Resident's personal property and managing the Resident's financial affairs. These rights may be exercised by you. So that you are aware of these rights the Facility's policy and procedure concerning these rights is at Exhibit 5.

D. The Resident's Right to Make Complaints and Suggest Changes in Policies and Services.

You, the Resident, or any other person may make complaints about the Resident's care in the Facility and may also suggest changes in the policies and services of the Facility. The Resident will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or service. You or the Resident may present the complaints orally or in writing to Facility staff or the Administrator, or to one of the following State agencies:

days paid by the Medicaid Program, the resident has the right to be readmitted to the first available gender and care-appropriate semi-private bed. Semi-private room means a two, three, or four-bed room. You may pay privately to reserve a bed for additional days.

The maximum number of days for which the Medicaid Program will pay to hold a bed for a leave of absence may be increased or decreased based upon changes in the law or the regulations established by the Maryland Medical Assistance Program

### **Hospitalization**

#### **3. Private Pay Residents:**

If the resident is private-pay, or are receiving inpatient care reimbursed under the Maryland Medicare Program (and the resident is not covered under Medicaid), we will hold a bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

#### **4. Medicaid Residents:**

If Medicaid pays for part or all of the resident's nursing home care or has filed an application for Medicaid and the resident's needs to be hospitalized, you may pay privately to reserve a bed for the days you are in the hospital. If your hospital stay exceeds the number of days you have paid the nursing home to reserve a bed, you have a right to be readmitted to the first available gender and care-appropriate semi-private bed. A hospital stay is not a leave of absence.

### **Third-party Payors**

5. Other third-party payors may or may not have a bed hold policy. We will discuss this if it applies to you.

#### **F. Transfer and Discharge.**

The Resident has the right to remain here, and may not be transferred or discharged against the Resident's will, except for the following reasons: (a) the Resident's condition has improved so that

If you or the Resident decide to end this Contract and the Resident leaves the Facility, the bill becomes due and payable on the day the Resident leaves. You or the Resident must give us 5 days notice to terminate this contract. If the Resident leaves before the end of that time, you must still pay for each day of the required notice unless we fill the bed before the end of the notice period.

In the event the Resident dies while a resident of the Facility, please designate who we should contact:

Relative or Friend: \_\_\_\_\_

Funeral Home: \_\_\_\_\_

Unless you have instructed us otherwise, we will immediately contact the individual(s) listed above to make funeral arrangements. If we are unable to reach the individual(s), we will contact the funeral home directly.

6. Additional Documents.

It is not possible to cover everything that is important to the Resident's stay in our Facility in the body of this Contract. Therefore, we have included additional important documents as Exhibits. These Exhibits are part of this Contract. Please verify that you received all of the Exhibits and that the contents of the Exhibits were explained to you. Place your initials on the line next to the description of each Exhibit.

\_\_\_\_\_ Exhibit 1. Obligations and Rights of an Agent.

\_\_\_\_\_ Exhibit 2. Private Pay:

A. Items and Services Included in the Daily Rate;

The parties have executed this Contract on the day listed below.

Manor Care of Wheaton MD, LLC

DBA ProMedica Skilled Nursing and Rehabilitation (Wheaton)

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: Administrator or Facility Designee

Date: \_\_\_\_\_

AGENT:

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

(Indicate whether you are: (1) a court-appointed guardian of the property (or of the person with court granted authority to handle the Resident's funds); (2) a power of attorney appointed by the Resident;<sup>6</sup> (3) a family member; or (4) other individual with access to (use, management, or control of) the income, funds and/or assets of the Resident.

Date: \_\_\_\_\_

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<sup>6</sup> By signing as Power of Attorney, I acknowledge I am signing an Agent as defined in this document and by Title 19, Health General Article, Annotated Code of Maryland.

(NOTE: Documentation verifying the above must be included in the Resident's record if a third-party's signature is required by the Facility.)

- B. PLEASE SELECT THOSE QUESTIONS WHICH DESCRIBE YOUR AUTHORITY FOR ACTING AS THE RESIDENT'S AGENT AND THEN INITIAL.

Are you signing this Contract (Select One):

\_\_\_\_\_ 1. At the request of the Resident?

\_\_\_\_\_  
Signature Verification of Resident –William Bevan

\_\_\_\_\_ 2. As a family member or other person with authority to manage, use or control the Residents income, funds and/or assets?

\_\_\_\_\_ 3. As a Guardian of the Property appointed by a Court?

\_\_\_\_\_ 4. As a financial Power of Attorney appointed by the Resident?

INITIALS: \_\_\_\_\_

(NOTE: The Agent shall provide documentation of his or her authority, where applicable.)

- C. AS THE RESIDENT'S AGENT, YOU HAVE CERTAIN OBLIGATIONS WHICH ARE LISTED BELOW. FAILURE TO MEET THESE OBLIGATIONS CAN RESULT IN CIVIL AND CRIMINAL PENALTIES AS DESCRIBED IN THIS EXHIBIT. INDICATE THAT YOU AGREE TO ASSUME EACH OBLIGATION BY INITIALING EACH IN THE SPACE PROVIDED.

Exhibit 1, Page 2

(NOTE: If it is ever determined that I knowingly or willfully participated in the disclosure of incomplete or inaccurate information, the incomplete or inaccurate disclosure is considered a breach of this Contract and the Facility reserves the right to pursue all available legal remedies against me including, but not limited to, an action for breach of contract.)

D. PENALTIES

I understand that I could be subject to both civil and criminal penalties for failure to meet my obligations as an Agent as follows:

1. If I willfully or with gross negligence fail to pay the required amounts from the Resident's income, funds or assets, as determined available by Medical Assistance, I understand that I could be subject to a civil money penalty for an amount at least equal to the amount due the Facility. This amount would be paid from my own funds.
2. If I willfully or with gross negligence fail to seek and pursue with due diligence on behalf of the Resident all assistance from Medical Assistance which may be available to the Resident, or fail to cooperate fully in the eligibility determination process, I understand that I could be subject to a civil money penalty of up to \$10,000. This amount would be paid from my own funds.
3. If I willfully or with gross negligence fail to cooperate and assist in the discharge planning process for the Resident, I understand that I could be subject to a civil money penalty of up to \$10,000. This amount would be paid from my own funds.
4. If I "abuse" the Resident's funds, I understand that I could be found guilty of a misdemeanor and, on conviction, be subject to a fine of up to \$10,000. This amount would be paid from

Exhibit 1, Page 4

- a. Pay for removal and storage of the property?  
Yes \_\_\_\_\_ [If yes, ( ) with the Resident's funds/  
( ) with your funds]  
  
No \_\_\_\_\_ Initials \_\_\_\_\_
- b. Pay for the room until you are able to move the Resident's personal property?  
Yes \_\_\_\_\_ [If yes, ( ) with the Resident's funds/  
( ) with your funds]  
  
No \_\_\_\_\_ Initials \_\_\_\_\_
4. If the Resident or his or her Representative wants to obtain private duty nurses or geriatric aides in accordance with the requirements of this Agreement, do you agree to be responsible to make arrangements for those services?  
Yes \_\_\_\_\_/No \_\_\_\_\_ Initials \_\_\_\_\_
5. Payment for services of private duty nurses or geriatric aides shall be made out of the Resident's income, funds and assets unless you agree to pay. Do you knowingly and voluntarily agree to pay for the services of private duty nurses from your own resources if these services are requested and the Resident does not have sufficient funds to pay for such services?  
Yes \_\_\_\_\_/No \_\_\_\_\_ Initials \_\_\_\_\_
6. In the event the Resident or his or her representative seeks to terminate this Contract, do you agree to give the notices required under Paragraph 5 of this Contract?  
Yes \_\_\_\_\_/No \_\_\_\_\_ Initials \_\_\_\_\_

Exhibit 1, Page 6

I, \_\_\_\_\_, have read the information in this Exhibit 1. I have had the opportunity to ask questions and I fully understand and accept all of the obligations I have in acting as the Resident's Agent.

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Administrator or Designee

\_\_\_\_\_  
Date

Exhibit 1, Page 8

The items and services available in the facility that are not included in the daily rate are listed below. The Resident may be charged for these items and services if you or the Resident (or the Resident's physician with the Resident's or your approval) ask for them and the Resident receives them. If the Resident is eligible for Medicare and/or private insurance and you believe that Medicare and/or the private insurance may cover an item or service listed below, you should ask us to submit the bill to Medicare and/or the private insurer. The services marked (\*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.

Description of Items & Services Not Included in the Daily Rate	Charge
Beauty and Barber*	Starting at \$10.00
Catheter Care* <ul style="list-style-type: none"> <li>• Catheter Charges – Indwelling Change</li> <li>• Catheter Charges – Intermittent Chg</li> </ul>	\$23.00 minimum per insertion  \$4.00 minimum per insertion
Colostomy Care* <ul style="list-style-type: none"> <li>• Ostomy Bag Change</li> </ul>	\$7.00 minimum per change
Decubitus Care* <ul style="list-style-type: none"> <li>• Simple Wound Treatment per Occ</li> <li>• Complex Wound Treatment per Occ</li> <li>• Wound Vacuum - Single Wound</li> </ul>	\$15.00 minimum per occurrence  \$50.00 minimum per occurrence  \$145.00 minimum per day

Exhibit 2, Page 2

Description of Items & Services Not Included in the Daily Rate	Charge
<ul style="list-style-type: none"> <li>Ntrtnl/Entrl Ser Group 1 per Servg</li> <li>Thickened Liquids Daily</li> <li>Nutrients - Specialized (Tube Feeding)- Glucerna 1.2</li> <li>Nutrients - Specialized (Tube Feeding)- Nepro with Carb Steady</li> <li>Nutrients - Specialized (Tube Feeding)- Glucerna</li> <li>Nutrients - Specialized (Tube Feeding)- Perative</li> <li>Ntrtnl/Entrl Ser Group 2 Per Servg</li> <li>Ntrtnl/Entrl Ser Grp 3 per 1500 Cal</li> </ul>	<p>\$1.00 minimum per serving</p> <p>\$5.50 minimum Daily Fee</p> <p>\$13.50 minimum per 1500 calories</p> <p>\$11.70 minimum per 1500 calories</p> <p>\$16.75 minimum per 1500 calories</p> <p>\$30.00 minimum per 1500 calories</p> <p>\$1.90/serving minimum per serving</p> <p>\$9.00 minimum per 1500 calories</p>
Incontinent Care* <ul style="list-style-type: none"> <li>Incontinent-Daily Fee</li> </ul>	\$5.75 minimum Daily fee
IV Therapy* <ul style="list-style-type: none"> <li>IV Therapy Supplies</li> <li>IV Pump Rental – Daily</li> <li>IV Start/Equipment Rental</li> </ul>	<p>Per vendor</p> <p>\$10.00 minimum per day</p> <p>\$1.00 minimum per day</p>
Laundry*	N/A

Exhibit 2, Page 4

Description of Items & Services Not Included in the Daily Rate	Charge
<ul style="list-style-type: none"> <li>○ Level 2 Mattress with Pump Daily</li> <li>○ Level 3 Clinitron (rental only)</li> <li>• Trapeze <ul style="list-style-type: none"> <li>○ Trapeze Floor Stand Rent Daily</li> </ul> </li> </ul>	<p>\$48.00 minimum per day</p> <p>\$140.00 minimum per day</p> <p>\$2.00 minimum per day</p>
<p>Suctioning*</p> <ul style="list-style-type: none"> <li>○ Gastric Drain Suction Rent Dly</li> <li>○ Pump Suct Aspirator Rent Daily</li> <li>○ Pump Suct Asprtr 800CC Daily</li> </ul>	<p>\$2.00 minimum per day</p> <p>\$2.00 minimum per day</p> <p>\$3.00 minimum per day</p>
<p>Tracheotomy Care*</p> <ul style="list-style-type: none"> <li>○ Standard Trach Bundle Daily</li> <li>○ Trach Item - Speaking Valve Change</li> </ul>	<p>\$36.00 minimum per day</p> <p>\$114.00 minimum per change</p>
<p>Other:</p> <ul style="list-style-type: none"> <li>○ Occupational Therapy Dysphagia Treat</li> <li>○ Occupational Therapy Eval</li> <li>○ Occupational Therapy Low Frequency Non-Thermal US</li> </ul>	<p>\$125.00 per 15 minute unit</p> <p>\$125.00 per 30-60 minute unit</p> <p>\$325.00 per 15 minute unit</p>

Exhibit 2, Page 6

Description of Items & Services Not Included in the Daily Rate	Charge
○ Physical Therapy All other CPT Codes	\$50.00 per 15 minute unit
○ Speech Therapy Bedside Swallow Eval	\$125.00 per 15 minute unit
○ Speech Therapy ENDSCPY SWAL TST	\$325.00 per 15 minute unit
○ Speech Therapy Eval Fluency/Stuttering	\$125.00 per 15 minute unit
○ Speech Therapy Eval Oral Speech Device	\$125.00 per 15 minute unit
○ Speech Therapy Eval Speech Sound Production	\$125.00 per 15 minute unit
○ Speech Therapy Eval Speech with Language	\$325.00 per 15 minute unit
○ Speech Therapy Eval Voice/Resonance	\$125.00 per 15 minute unit
○ Speech Therapy FEES W/LARNGL TST	\$325.00 per 15 minute unit
○ Speech Therapy LARYSCPY SENS TST	\$325.00 per 15 minute unit
○ Speech Therapy Motion FLR SWAL	\$125.00 per 15 minute unit
○ Speech Therapy – Routine	\$15.00 per 15 minute unit
○ Speech Therapy SGD TX	\$125.00 per 15 minute unit
○ Speech Therapy SP/Lang Treat	\$125.00 per 15 minute unit
○ Speech Therapy Swallowing Treat	\$125.00 per 15 minute unit

Exhibit 2, Page 8

Description of Items & Services Not Included in the Daily Rate	Charge
<ul style="list-style-type: none"> <li>○ Monoclonal Antibodies Administration</li> <li>○ Nebulizer Pulmonate Comp RTDY</li> <li>○ Nebulizer Rental Daily</li> <li>○ Nonlegend Pharmacy</li> <li>○ Personal Purchases</li> <li>○ Pharmacy IV Drugs</li> <li>○ Phone Services</li> <li>○ Physician Visit</li> <li>○ Pneumococcal Vaccine</li> <li>○ Pneumococcal Vaccine Administration</li> <li>○ TB Test</li> <li>○ Telehealth Originating Site Fee</li> <li>○ Television and Cable Services</li> <li>○ Transportation Services</li> <li>○ Ventilator Rental Daily</li> </ul>	<ul style="list-style-type: none"> <li>\$450.00 per administration</li> <li>\$1.00 minimum per day</li> <li>\$2.50 minimum per day</li> <li>Per vendor</li> <li>Per fee</li> <li>Per vendor</li> <li>N/A</li> <li>Per fee</li> <li>\$125.00 minimum per vaccine</li> <li>\$40.00 per vaccine</li> <li>Per vendor</li> <li>\$27.59 minimum per visit</li> <li>N/A</li> <li>Per fee</li> <li>\$33.00 minimum per day</li> </ul>

Exhibit 2, Page 10

	MEDICARE	MEDICAID
	9. Medically necessary doctor's services.	
YOUR CONTRIBUTION	Medicare does not pay 100% of the cost of covered services. You will be required to pay part of the charges. Your payment may be called a "copayment," "deductible" or "premium," depending on the type of care provided. If you receive Medicaid, Medicaid may pay for any payment that you are responsible for under Medicare.	Depending on your income, you may be required to make a contribution toward the cost of your care. The amount of any contribution will be calculated by the local Department of Social Services. You will need to pay this contribution to the Facility for every month in which you are eligible for Medicaid, including partial months.
WHO'S ELIGIBLE	People 65 years old or older who are eligible to collect old-age benefits under Social Security are eligible. Persons who receive Social Security disability benefits for at least 24 months, or have been found eligible for Medicare by the Social Security Administration because they have end stage renal disease requiring regular dialysis or kidney transplant are also eligible.	Eligibility is based on your income and resources (assets):  1. <u>Resources</u> : The local Department of Social Services will evaluate your resources (assets) and tell you whether you qualify. Generally, you cannot have more than \$2,500 in resources. The following are examples of things <u>not</u> counted as resources:

Exhibit 3A, Page 2

	MEDICARE	MEDICAID
		<p>personal use while in the Facility.</p> <p>2. <u>Assets</u>: The local Dept. of Social Services will also be able to evaluate your assets and tell you whether you qualify.</p>
		<p>NOTE: You will not be eligible for some period of time if you have transferred resources for less than fair market value to someone other than your spouse, or a blind or disabled child, within thirty-six months before you apply for Medicaid.</p> <p>2. <u>Income</u>: If your income is less than the facility's private pay rate, you may be eligible. If you qualify, \$40.00 per month of your income is protected for your personal use while in the facility. Medicaid may protect other</p>

Exhibit 3A, Page 4

**EXHIBIT 3B  
MEDICAL ASSISTANCE  
NURSING FACILITY SERVICES**

**Important Information - Please Read Carefully**

The Medical Assistance Program, also known as Medicaid, is a governmental program to help people pay their medical bills. To be eligible, one must be financially unable to pay the cost of medically necessary care. Eligibility, therefore, has two tests: (1) financial eligibility; and (2) medical eligibility. Financial eligibility is determined by the local Department of Social Services. Medical eligibility is determined by the Medical Assistance Program.

It is important to understand that even if you can no longer afford to pay for nursing facility care, Medical Assistance will not pay for nursing facility services unless you are also medically eligible for these services. You may obtain information regarding financial eligibility from the local Department of Social Services at no cost. If you want to know if you are medically eligible before you apply for Medicaid Assistance, for a nominal fee, you may obtain an assessment of your medical eligibility from the same contractor who currently functions as the State Review Agent for the Medical Assistance Program.

To obtain an assessment of your potential medical eligibility, you may call the current State Review Agent, Telligen at (888)276-7075 or you may write to Telligen at:

Telligen  
10330 Old Columbia Road,  
Suite 101,  
Columbia, MD 21046

Medical conditions of nursing facility residents change over time. Therefore, the assessment you receive is advisory only and is not binding on the Medical Assistance Program. The assessment will, however, assist you in making an informed decision regarding your need for nursing facility care or for less intensive

Exhibit 3B, Page 1

**EXHIBIT 4**  
**FOR MEDICARE AND MEDICAID RESIDENTS**

**Items and Services Not Covered By Medicare or Medicaid**

Items and services not covered by Medicare or Medicaid and related charges are listed below. You may be charged for these items and services if the Resident or you (or the Resident's physician with the Resident's or your approval) ask for and receive them. The services marked with an (\*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.

<b><u>Item or Service</u></b>	<b><u>Charge</u></b>
Audiology Services;	Per vendor
Beauty Salon and Barber Shop*;	Starting at \$10.00
Cosmetic and Grooming Items;	Per fee
Dental Services (Billed by Dentist)	Per vendor
Flowers and Plants;	Per fee
Newspapers (and other reading materials);	Per fee
Occupational and Physical Therapy Services*; (unless they are part of a specialized rehabilitative therapy services program meeting certain regulatory requirements);	Services starting at \$15.00
Personal Clothing;	Per fee
Personal Comfort Items (including smoking materials);	Per fee
Private Rooms**;	See Center Supplement
Privately Hired Nurses and Aides;	Per vendor
Services of Other Health Care Providers [Attach Facility Specific List];	

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\*\* If you receive Medicaid and the Facility places you in a private room, the Facility may not charge you or anyone else an additional cost for a private room.

**EXHIBIT 5**  
**POLICIES AND PROCEDURES CONCERNING THE RESIDENT'S**  
**PERSONAL FUNDS AND THE RESIDENT'S**  
**PERSONAL PROPERTY**

**A. The Resident's Rights**

1. The Resident has the right to keep and use the Resident's personal property, including some furnishings and clothing, so long as there is enough space and other residents are not inconvenienced. The Resident also has the right to security for the Resident's personal possessions.

2. We cannot require the Resident to deposit the Resident's personal funds with us. The Resident may, however, choose any person to manage the Resident's funds, including the Facility.

3. If the Resident decides to have us manage the Resident's personal funds during the Facility's business hours, the Resident may withdraw the Resident's money that we keep in the Facility. If we have deposited any of the Resident's funds in a bank, the Resident may obtain those funds within three banking days, provided the funds have cleared.

4. If the Resident needs help to perform the Resident's banking transactions, the Resident may give an employee of our Facility who has been approved by the Administrator legal authority to access the Resident's account. This authority is called a "limited power of attorney." To give an employee this authority, the Resident will need to complete a special form. The form has been approved by the Maryland Department of Health and is available in the facility.

5. The Resident has the right, during normal business hours, to inspect our written records that concern the Resident's personal funds.

6. The Resident or any other person acting on the Resident's behalf has a right to file a complaint if it is believed that the Resident's

3. If the Resident wants us to manage more than \$50.00 of the Resident's personal funds, we will deposit this money in an interest bearing account that is insured by the federal government. This account will be separate from the accounts we use to operate the facility. In addition, we will credit the Resident with all interest earned on the Resident's money.

4. We will maintain a full, complete and separate monthly accounting of the Resident's personal funds, which is available to you for inspection. We will also provide the Resident with a quarterly statement of the activity of the Resident's account.

5. If the Resident receives Medicaid benefits, we will notify the Resident if the Resident's account balance becomes too high. If the Resident is to remain eligible for Medicaid, the Resident's account balance must be under a certain dollar limit that is established by the federal government and may change periodically.

6. We may not use the Resident's personal funds to pay for an item or service that Medicare or Medicaid covers.

7. We will maintain adequate fire and theft coverage to protect the Resident's funds and personal property that are kept at the Facility. We shall also obtain a surety bond or otherwise assure\* the security of the Resident's personal funds that are deposited with the Facility.

8. If the Resident is discharged, there are several things we must do:

- a. We will immediately return the Resident's personal funds in our possession. If we have deposited the Resident's personal funds in a bank account, we will

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\* CMS has determined that neither self-insurance nor FDIC insured accounts are an acceptable alternative.

Resident's heirs. If no claim is made on the Resident's funds, valuables or other assets in our possession within six weeks of the Resident's death, we will write the State Office of the Comptroller for direction.

10. If we are in possession of the Resident's funds, valuables or other assets for more than one year from the date of the Resident's transfer or discharge, we will transfer the Resident's funds, any interest on the Resident's funds, and the Resident's valuables or other assets to the State Office of the Comptroller. We will also notify the Comptroller's Office of any account(s) in the Resident's name of which we have knowledge.

Exhibit 5, Page 5

**EXHIBIT 7**  
**SERVICES PROVIDED BY OUTSIDE HEALTH CARE PROVIDERS**

Some of the services available in the Facility, such as pharmacy services, are provided by outside health care providers. These services, and information about the providers, appear below. The Resident's own provider or one of those listed below may be used.

Type of Service	Provider's Name, Address & Telephone Number	Whether the Facility Has a Shared Ownership Interest with the Provider
Radiology/Lab - American Health Associates: 10290 Old Columbia Rd, Suite 302, Columbia, MD 21046 : 410-381-0102 : No Shared Interest		
Pharmacy - Heartland Pharmacy: 9070 Junction Dr, Suite E Annapolis, MD 20701 : 301-498-7410 : Shared Interest		
Podiatry - HealthDrive: 6700 Alexander Bell Dr, Suite 200, Columbia MD 21046 : 888-964-6681 : No Shared Interest		
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## Skilled Nursing and Rehabilitation Centers Patient Information Handbook

### Our Center and You

Just as you value your choices, we value respecting them.

ProMedica's person-centered care focus allows for individuality, preference, and dignity coupled with a sense of community. Our philosophy of person-centered care means that you will receive the help and support you need to reach your healthcare goals without losing choice and autonomy.

Do you prefer a shower or a bath? What time would you like to go to bed at night? What would you like to eat for dinner? Is there a certain routine you followed at home that you would like to continue while at our center?

These are just a few of the choices that are yours to make at one of our centers. Your healthcare team will strive to make our center feel like your home while getting to know you as a person, not a patient.

### What to Expect

Most likely, you have just come from a hospital stay and you may be anxious about your time at our center. We can't answer all of your questions in this handbook so please don't hesitate to ask us questions or voice concerns.

For some patients, our center will become their home. For many patients, their stay with us is a short term visit to recover from surgery, an injury or a serious illness... before going home.

The cornerstone of care is your care team. Quality care begins by getting to know your primary care nurse, certified nursing assistants and therapists who will be assisting you. It is important that you and your family discuss any care concerns with them and alert them to any physical, mental or emotional changes.

Your care will be under the direction of a licensed physician. Although you won't see your doctor as often as you did in the hospital, our staff members will be in regular contact with your personal physician. It's important that you or your family members remain in contact with your physician as well.

Our center accepts Medicare, private payment and most insurance plans. Many of our centers also accept Medicaid. More information about Medicare and Medicaid can be found in the Appendix in the back of this handbook.

As part of our effort to maintain an independent and dignified lifestyle as well as to ensure patient rights, we make every effort to avoid using physical or chemical restraint. We encourage the least restrictive environment to promote optimal level of functioning and independence.

### Your Health Care Team

#### PHYSICIANS

During your stay, your care will be supervised by your attending physician, who in most cases is not a ProMedica employee. You will have the right to choose any licensed physician who agrees to comply with our policies and applicable rules. Please give us your physician's name and tell us if you wish to change physicians. If your physician does not comply with our policies, we will identify another physician to care for you to ensure you receive proper care.

#### NURSES AND ASSISTANTS

Nursing care is provided under the direction of a professional Registered Nurse or Licensed Practical Nurse. The Director of Nursing in coordination with physician's orders. Licensed nurses and nursing assistants are available to ensure you receive proper care.

#### THERAPISTS

We offer several types of therapy services to help you obtain your best outcomes. The services we offer generally include: physical therapy, occupational therapy, and speech therapy. Your attending physician will order therapy for you if it is appropriate.

#### PHARMACISTS

Medications prescribed by your physician will be obtained from a licensed pharmacy. You have the choice to use our pharmacy or your own pharmacy. You can use your own pharmacy as long as the pharmacy complies with our requirements for stocking and packaging your medications. If your pharmacy cannot comply with these requirements, we will notify you and use our pharmacy provider.

#### SOCIAL SERVICES

Social services can help you plan for discharge, identify sources of financial assistance, refer you to community resources for support regarding your health care needs and arrange for appropriate care after you are discharged from our center.

#### ACTIVITIES

Our center's activity programming is designed to recognize and accommodate any limitations you may have while maximizing your strength, interest, and abilities. A variety of recreation options are available to promote cognitive, physical, social, and sensory stimulation.

We make every effort to provide a home-like and comfortable environment. We encourage patients to live at their highest practicable level. Our employees are dedicated to quality care. We have instructed them to not accept tips or gifts from patients, families or visitors. However, a verbal or written communication of appreciation is always appreciated.

## Skilled Nursing and Rehabilitation Centers Patient Information Handbook

### TRANSPORTATION

Depending on your payer source, you may be responsible for arranging and paying for transportation to and from your appointments. If needed, we will assist you with your transportation arrangements.

### MAIL

Mail and other deliveries will be brought to your room. Mail received after you have been discharged will be forwarded. A mailbox is available for outgoing mail and center staff is available to assist with opening, reading and sending mail, if needed.

### FOOD SERVICE

The center's Dietary Manager works closely with a registered dietitian and other health care team professionals to provide nutritious meals and education to meet your specific needs. Meals are served daily in the dining room at regular hours. You may also dine in your room. Snacks are available in-between meals and upon request. Your guests may dine with you at an additional charge. Please notify a member of the center staff if you wish to receive guest food trays.

If you decide to keep food in your room, it must be in an airtight container and dated. Perishable items should be marked with your name and the date. Please give it to a staff member for storage in a refrigerator.

### LAUNDRY

We will launder your personal items at your request. Or, your family can provide laundry services for you. This service is included in the daily room and board rate for Medicare and Medicaid patients. There is an additional charge for patients who pay privately. Please label your personal items with a laundry pen.

### EQUIPMENT

You are responsible to provide your own equipment including wheelchairs, walkers, and canes. You may rent equipment from the center or other independent suppliers if needed. Equipment owned by the center should not be removed from the center without prior permission from center staff. The Maintenance Department will routinely check equipment to make sure it functions properly.

### RESIDENT TRUST FUND

We offer a resident trust fund which is a separate account for your personal funds. These funds can be used to pay for personal items such as beauty shop visits.

## Care Line

### FOR COMPLIMENTS, CONCERNS AND COMPLAINTS

Most of your questions or concerns regarding patient care or service can be quickly answered by our management team at this

Your call or email will be answered and referred to the appropriate manager for follow-up. This is a confidential service for our families and employees.

Your center Administrator serves as the Grievance Officer. The Grievance Officer is responsible for overseeing the process in the center.

## Notices

### ADMISSION POLICY

When making the admission decision, we will admit and treat persons without regard to race, color, national origin, and religion, sex/gender (including pregnancy), sexual orientation, gender identity or gender expression, age, physical or mental disability, military or protected veteran status, citizenship, or marital status, genetics or any other legally protected characteristic. Each admission will be considered on an individual basis to determine whether the facility can meet the patient's needs without jeopardizing the safety of other patients.

- Services are available to patients as prescribed by the physician outlined in the care plan.
- There is no distinction in eligibility for, or in the manner of providing patient services.
- Patients are assigned to personnel on a non-discriminatory basis.
- Patients diagnosed with a contagious disease including but not limited to HIV, MRSA and Hepatitis B, will not be admitted unless the State Health Department or Center for Disease Control advise otherwise. Patients must meet admission criteria.
- Concerns regarding compliance with Section 504 of the Rehabilitation Act of 1973 (non-discrimination against the handicapped) can be directed to the Care Line at 1-800-848-2222.

This statement is in accordance with the provision of Title VII of the Civil Rights Act of 1964 (non-discrimination on the basis of race or color or national origin), Section 504 of the Rehabilitation Act of 1973 (non-discrimination on the basis of age) and Regulation 45 of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84.

### SPECIAL NEEDS COMMUNICATION

We are committed to communicating with sensory impaired and persons with limited English proficiency. If you need assistance with understanding communication because of a hearing, sensory or sight impairment, we will provide the appropriate interventions to help with communication.

### ADVANCE DIRECTIVES

You have the right to make decisions about your own health

## Skilled Nursing and Rehabilitation Centers Patient Information Handbook

# Index of Information

### Topic

Admission policy  
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## Skilled Nursing and Rehabilitation Centers Patient Information Handbook

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

**3. Routine uses of records maintained in the system.** The information collected will be entered into the LTC MDS system of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

- (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;
- (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;
- (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;
- (4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;
- (5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

(7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

(8) To assist a CMS contractor (including but not limited to intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to assist a grantee of a CMS-administered grant program to conduct fraud, waste and abuse in certain health benefit programs;

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local government agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

**4. Effect on individual of not providing information.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid, and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

## Notice of Information Practices

**This Notice ("Notice") describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.**

We have summarized our responsibilities and your rights in the first section. For a complete description of our privacy practices, please review this entire Notice.

### OUR RESPONSIBILITIES

We are required to:

- Maintain the privacy of your health information;
- Provide you with this Notice of our legal duties and information practices with respect to information we collect and maintain about you;
- Abide by the terms of this Notice currently in effect; and
- Notify you following a breach of unsecured protected health information.

## Skilled Nursing and Rehabilitation Centers Patient Information Handbook

**NEWSLETTERS / BULLETIN BOARDS.** Some of our business units have bulletin boards and newsletters that are distributed to staff and residents. If applicable, we may post your name and birth date on a bulletin board and in a newsletter, unless you notify us.

**RESEARCH.** We may disclose information to researchers when certain conditions have been met.

**TRANSFER OF INFORMATION AT DEATH.** We may disclose health information to funeral directors, medical examiners, and coroners to carry out these duties consistent with applicable law.

**ORGAN PROCUREMENT ORGANIZATIONS.** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**FOOD AND DRUG ADMINISTRATION (FDA).** We may disclose to the FDA, or to a person or entity subject to the jurisdiction of the FDA, health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**WORKERS' COMPENSATION.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

**PUBLIC HEALTH.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**CORRECTIONAL INSTITUTION.** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents your health information necessary for your health and the health and safety of other individuals.

**LAW ENFORCEMENT.** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**REPORTS.** Federal law allows a member of our work force or a business associate to release your health information to an appropriate health oversight agency, public health authority or attorney, if the work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**REQUIRED BY LAW.** We may use or disclose your health

### USES AND DISCLOSURES THAT MAY BE MADE EITHER WITH YOUR AGREEMENT OR THE OPPORTUNITY TO OBJECT

**DIRECTORY/LIST OF PATIENTS.** Unless you notify us that you object, we may use your name, location in the facility (if applicable), general condition, and religious affiliation for directory purposes. We may release information in our directory except for your religious affiliation, to people who ask for your name. We may provide the directory information, including religious affiliation, to any member of the clergy.

**NOTIFICATION.** Unless you notify us that you object, we may use or disclose information to notify or assist in notifying a family member, responsible party, or another person responsible for your care, of your location and general condition. If we are unable to reach your family member or responsible party, then we may leave a message for them at the phone number that they have provided us, e.g. on an answering machine.

**COMMUNICATION WITH FAMILY.** Unless you notify us that you object, we may disclose to a family member, other relative, close personal friend or any other person involved in your care, health information relevant to that person's involvement in your care or payment related to your care. If appropriate, communications may also be made after your death, unless you have instructed us not to make such communications.

### USES AND DISCLOSURES OF YOUR HEALTH INFORMATION BASED ON YOUR WRITTEN AUTHORIZATION

**PSYCHOTHERAPY NOTES.** We must obtain your written authorization for most uses and disclosures of psychotherapy notes.

**MARKETING.** We must obtain your written authorization to disclose your health information for most marketing purposes. We may contact you regarding your treatment, to coordinate care, or to direct or recommend alternative treatments, treatments, health care providers or settings. In addition, we may contact you to describe a health-related product or services that may be of interest to you, and the payment for such product or service.

**SALE OF HEALTH INFORMATION.** We must obtain your written authorization for any disclosure of your health information that constitutes a sale of health information.

**OTHER USES.** Other uses and disclosures of your health information, not described above, will be made only with your written authorization (unless otherwise permitted or required by law). You may revoke your authorization, at any time, in writing except to the extent we have taken action in reliance on your authorization.

### ADDITIONAL RESTRICTIONS ON USES AND DISCLOSURES

**Notes:**

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

## 2023 RATES

*Understanding Skilled Nursing* **Medicare Benefits****WHEN DO MEDICARE BENEFITS APPLY TO ME?**

Medicare is designed for those needing short term medical care. You can receive Medicare benefits under most circumstances if:

- You have been admitted to the hospital for three consecutive days\*\*, not counting the day of discharge,
- You are transferred to a nursing center for further care of the condition that was treated in the hospital or other conditions requiring skilled nursing or rehabilitative services,
- Your physician certifies that you require skilled or rehabilitative care after the hospital stay.

**HOW DOES MEDICARE COST COVERAGE WORK?**

Medicare Part A will pay 100% for your first 20 days in a Medicare certified skilled care facility. Days 21-100, Medicare will pay a portion of your care. You will be responsible for the balance or co-pay.

Your co-pay responsibility, days 1-20:	<b>\$0.00</b>
Your co-pay responsibility, days 21-100:	<b>\$200.00***</b>

**WHAT ABOUT PART B COVERAGE?**

Part B services are usually those services provided by an outside provider like physician services, x-rays, therapy, labs, certain ambulance fees and nutrition supplies. In 2010, Medicare mandated Part B enrollees to pay Part B premiums based upon their income. Our admission team can provide you with additional information.

Part B deductible is:	<b>\$226.00***</b>
and there is a 20% Part B co-pay on allowable charges.	

\* Additional information about Medicare coverage can be found at [medicare.gov](http://medicare.gov).

\*\* To ensure your post-hospital stay benefits, check with the hospital social services to ensure that you have been admitted and are not under observation care status.

\*\*\* As of January 1, 2023

**WHAT ELSE SHOULD I KNOW ABOUT MEDICARE?**

Ask our admission team about follow-up care and the 30-day window coverage. If you feel you need more care or have additional issues with your health care condition, Medicare might still cover your skilled nursing or rehabilitative needs.

**ABOUT US**

As a division of ProMedica, a not-for-profit, mission-based organization, we are working to create a stronger, more cohesive approach to delivering care at the right place, right time and right cost. As part of ProMedica, a complete health care system, our services span the full spectrum of care including wellness, acute care, skilled nursing care, memory care, assisted living, hospice, home health, palliative care, a physician organization, an academic affiliation and a health plan. Our goal is to redefine, transform and improve the health and well-being of an aging population. Driven by its Mission to improve your health and well-being, ProMedica has been nationally recognized for its advocacy programs and efforts to address social determinants of health.

To learn more about our services and our commitment to our community, or to make a referral, please call us today.

**Your Health. Our Mission.**



[promedicas skillednursing.org](http://promedicas skillednursing.org)

PMSN-0015

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**Receipt of Notice of Information Practices - MD**

Patient's Name: William Bevan

I acknowledge receipt of Center's Notice of Information Practices which is included in the Patient Information Handbook.

I ☐ agree ☐ object to including William Bevan location in the facility, general condition and religious affiliation (available to clergy only) in the Facility Directory.

I ☐ agree ☐ object to disclosure of William Bevan health information to a family member or close personal friend, including clergy, who is involved in my care.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Assignment for Payment of Benefits**

Patient's Name: William Bevan

I assign Center the right to bill and receive money directly from my insurance company, third party payer or governmental payer. I authorize the Center and holder of medical or other information to release such information to the Centers for Medicare & Medicaid Services and its agents and to third party payers any information needed to determine my benefits and the Center's right to receive payment. If I do not want Center to bill my insurance company or other provider, and decide to pay privately, I will notify Center in writing of this request.

\_\_\_\_\_  
Signature of Resident or Resident's Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## REGULATORY AND ADVOCACY AGENCIES

### Know Your Rights: Advocacy Organizations

In accordance with federal guidelines, we recognize:

- Patients have the right to contact State and local advocacy organizations
- Patients may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements, and requests for information regarding returning to the community

### CONTACT INFORMATION FOR YOUR STATE AND LOCAL ADVOCACY ORGANIZATIONS:

- **State Survey Agency**  
Maryland Department of Health: 201 W Preston St, Baltimore, MD 21201 : 410-767-6500
- **State Licensure Office**  
Office of Health Care Quality: 7120 Samuel Morse Dr, Second Flr, Columbia, MD 21046 : 410-402-8108
- **State Long-Term Care Ombudsman Program**  
10 N Calvert St # 300, Baltimore, MD 21202 : 410-396-3144
- **Protection and Advocacy Agency**  
Montgomery County Aging Unit: 401 Hungerford Dr, Rockville, MD 20850 : 240-777-3000
- **Adult Protective Services**  
Maryland Department of Human Services: 311 W Saratoga St, Baltimore, MD 21201 : 800-332-6347
- **Medicaid Fraud Control Unit**  
Office of the Attorney General: 200 St. Paul Place, 18th Flr, Baltimore, MD 21202 : 410-576-6521 : MedicaidFraud@oag.state.md.us
- **Local Agencies with Information Regarding Return to the Community**

Montgomery County Aging Unit: 401 Hungerford Dr, Rockville, MD 20850 : 240-777-3000
Disability Rights Maryland: 1500 Union Ave, Suite 2000, Baltimore, MD, 21211 : 410-727-6352
Language Line Solutions: 866-874-3972
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## Welcome and thank you for choosing our Center!

In addition to the Maryland Standard Admission Agreement – Resident’s Agent Financial Agreement, we are also providing additional information in the Patient Information Handbook and this Center Supplement. The parties are defined as follows:

- The “Center” or “Facility”: Manor Care of Wheaton MD, LLC doing business as: ProMedica Skilled Nursing and Rehabilitation (Wheaton)
- The “Patient” or “Resident”: William Bevan and
- The “Responsible Party” (if any): \_\_\_\_\_.

Patient, Resident and Responsible Party are collectively referred to as “You” or “you” in this Center Supplement and Patient Information Handbook.

### ADMINISTRATIVE TEAM

Administrator: AJ Adeniyi-Oladapo

Director of Nursing: Henock Mitiku

Admissions: Kezley Lighty

Social Services/Discharge Planning: Jay House

Medical Director: Dr. Merlyn Vemury

### ROOM AND BOARD RATE

If your care is not covered by another source, our private pay monthly rates are:

Private Skilled Room: \$20,150.00	Semi-Private Room: \$20,150.00
Private Intermediate Room: \$12,658.94	Semi-Private Intermediate Room: \$11,803.61
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### SMOKE-FREE CAMPUS

For everyone’s health, the Center is a smoke free environment, both indoors and outdoors. Because we have a smoke-free campus, no patients are allowed to have any smoking materials, including, but not limited to, lighters, matches, cigarettes, e-cigarettes, pipes, and cigars, on the campus. If you are interested in receiving help to stop smoking, please contact Center staff.

# **VOLUNTARY ARBITRATION AGREEMENT**

### VOLUNTARY ARBITRATION AGREEMENT

This is a Voluntary Arbitration Agreement ("Agreement") between:

The "Center": Manor Care of Wheaton MD, LLC doing business as  
ProMedica Skilled Nursing and Rehabilitation (Wheaton);

The "Patient": William Bevan; and

The "Patient's Representative" (if any): \_\_\_\_\_.

1. **Voluntary Agreement to Arbitrate Disputes.** The parties agree that they will mutually benefit from the speedy and efficient resolution of any dispute or controversy which may arise between them. This is a voluntary Agreement to have all disputes resolved through binding arbitration by an independent neutral Arbitrator who will be selected by the parties as specified in this Agreement. **THE PARTIES AGREE THAT THEY ARE WAIVING THE RIGHT TO TRIAL BY JURY. ANY DISPUTES BETWEEN THE PARTIES WILL BE RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION.**
2. **Parties.** This Agreement and the definitions in this Section will be interpreted as broadly as possible so as to bind and benefit any person who asserts any claim or against whom a claim is asserted by or on behalf of the Center or the Patient. The parties intend to allow any person alleged to be liable for any actions or inactions of the Center or the Patient or related to any care provided to the Patient to demand arbitration pursuant to this Agreement.
  - a. "Center" includes the Center's licensed operator, governing body, officers, directors, members, shareholders, administrator, employees, managers, agents, and any parent company, subsidiary, or affiliates, including but not limited to ProMedica Health System, Inc. and any of its affiliates, and any person or entity alleged to be responsible for the Center's activities.
  - b. "Patient" includes the Patient, the Patient's Representative, the Patient's guardian, attorney-in-fact, agent, sponsor, or any person whose claim is derived through or on behalf of the Patient, including any spouse, child, parent, executor, administrator, personal representative, heir, or survivor, as well as anyone entitled to bring a wrongful death claim relating to the Patient. The Patient is an intended third-party beneficiary of this Agreement.
3. **Federal Arbitration Act Applies.** The parties agree that the Center's business activities substantially affect interstate commerce. This Agreement is governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16 (the "FAA"), as opposed to state arbitration law.
4. **Arbitration Demand.** Arbitration is initiated by sending a written demand ("Demand") to the other party by certified mail or commercial overnight delivery (e.g., FedEx or UPS.). A Demand must identify the issues in dispute and the amount claimed. All claims based in whole or in part on the same incidents or admissions covered by this Agreement must be included in the Demand or otherwise be deemed waived upon the conclusion of the arbitration. A claim is barred if not asserted in a Demand within the limitation period prescribed by state law. If a Demand is issued to the Center, a copy must also be sent by certified mail or commercial overnight delivery to: ProMedica Legal Department, 100 Madison Avenue, MSC-S3-9938, Toledo, Ohio 43604.
5. **Selection of Arbitrator.** After a proper Demand is made, the parties will work cooperatively to select a neutral arbitrator. If the parties cannot agree upon an arbitrator, each party will, within thirty days after the receipt of the Demand, appoint a neutral arbitrator, and these two individually selected neutral arbitrators will select a third neutral arbitrator to comprise a panel of three neutral arbitrators to hear the dispute. The arbitrator and/or panel of three are collectively referred to as "Arbitrator." If one of the parties fails to respond to a Demand or name a representative, the other party may either: (i) select the Arbitrator from the

16. **Admission and Care Unaffected.** Signing this Agreement is not required in order for the Patient to be admitted into the Center or to continue to receive care at the Center. The same level of care will be provided whether or not the Agreement is signed. The Patient may discuss this Agreement with his or her attorney before signing.
17. **Right to Cancel.** The Patient may cancel this Agreement by writing "cancelled" on the face of one of the Patient's copies of the Agreement, signing the Patient's name under such word, and mailing, by certified mail, return receipt requested, the copy to the Center within thirty (30) days of signature. Filing of a medical claim in a court within the thirty days provided for cancellation of the Arbitration Agreement by the Patient will cancel the Agreement without any further action by the Patient.
18. **Confidentiality.** All proceedings and materials related to the Arbitration including all depositions, documents, and other materials are confidential. All originals and copies of documents exchanged during discovery and the arbitration hearing must be returned to the producing party within 30 days following receipt of the Arbitrator's decision. The Center will maintain the arbitrator's decision for 5 years after the resolution of the dispute and, upon request, will make the decision available for inspection to CMS or its designee.

**THIS ARBITRATION AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ THE AGREEMENT IN ITS ENTIRETY BEFORE SIGNING. EACH PARTY IS WAIVING THE RIGHT TO TRIAL BY JURY. DISPUTES MUST BE RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION. I ACKNOWLEDGE THAT MY SIGNATURE BELOW INDICATES THAT THIS AGREEMENT HAS BEEN EXPLAINED TO ME AND THAT I UNDERSTAND IT.**

**PATIENT:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SIGNATURE OF PATIENT'S REPRESENTATIVE**

My signature indicates that I am authorized, or have apparent authority, to sign on behalf of the Patient. I represent that the Patient has vested in me the authority to sign this Agreement on the Patient's behalf.

By: \_\_\_\_\_

Signature

\_\_\_\_\_  
Date

Print Representative's Name: \_\_\_\_\_

**SIGNATURE OF CENTER REPRESENTATIVE:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

**Acknowledgment of Receipt of Documents**

I acknowledge that I have received a copy of the following documents:

1. Maryland Standard Admission Agreement – Resident’s Agent Financial Agreement
2. Patient Information Handbook
3. Understanding Medicare
4. Consent to Treat
5. Receipt of Notice of Information Practices
6. Resident Trust Fund Notification
7. Medicare Secondary Payor Questionnaire
8. Assignment for Payment of Benefits
9. Maryland Nondiscrimination Statement
10. Regulatory and Advocacy Agencies Listing
11. Center Supplement
12. Voluntary Arbitration Agreement

I have been able to ask questions and receive answers to my questions.

\_\_\_\_\_  
Signature of Resident or Resident’s Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

panel of neutrals of any commercial arbitration service operating within the Center's state, or (ii) ask a court to appoint a representative to assist in the selection of the Arbitrator.

6. **Arbitrator's Authority.** The Arbitrator has the sole jurisdiction to resolve all disputes among the parties, including wrongful death claims and any disputes about the signing, validity, enforceability, scope, applicability, interpretation, severability and waiver of this Agreement or competency of the parties. The Arbitrator does not have jurisdiction to certify any person as a representative of a class of persons and, by doing so, hear claims of persons not directly taking part in arbitration.
7. **Scheduling Order and Hearing.** With the input of the parties, the Arbitrator will enter a scheduling order in keeping with arbitration being a streamlined process with expedited and limited discovery. Unless the parties consent or the Arbitrator otherwise orders, the hearing must occur within 180 days after selection of the Arbitrator. Unless the parties otherwise agree, the Arbitrator will conduct the arbitration hearing at a location near the Center.
8. **Venue.** Unless otherwise agreed by the parties, the arbitration will take place in the county where the Center is located. If proceeding in the county where the Center is located is inconvenient to the Patient, the parties will select a mutually convenient venue.
9. **Refusal to Participate.** In the event that any party refuses to respond to a Demand or participate in arbitration, the party making the Demand may proceed with arbitration and obtain an award or a default award against the non-participating party.
10. **Counsel and Attorneys' Fees.** Each party may be represented by its own counsel in the arbitration. Each party agrees to bear its own attorneys' fees and costs, unless otherwise specifically awarded by the Arbitrator under state or federal law.
11. **Arbitration Fees.** In collection actions, the fees are split 50/50. In all other disputes, the Center will pay the fees of the Arbitrator unless the Patient requests to pay a portion of the fees.
12. **Decision.** The Arbitrator must make written findings on each matter in controversy. The decision must be marked "confidential," must state the Arbitrator's findings of fact and conclusions of law, and must be signed. Unless preempted by the FAA, the Arbitrator will apply federal law or the substantive law of the state where this Agreement is entered and that would have applied had the claims been brought in court, including any limitation periods and any caps on damages. If any damages are awarded, the decision must specify an amount for each type of damages awarded.
13. **Severability.** The Parties agree that the only essential term to this Agreement is the agreement and willingness of both parties to arbitrate. Accordingly, if any provision of this Agreement is determined to be invalid or unenforceable, in whole or in part, the remaining provisions remain in full force and effect.
14. **Merger.** Upon execution, this Agreement shall merge into and become part of the written Admission Agreement pursuant to which the Patient is admitted to the Center unless it is cancelled as described in paragraph 17 of this Agreement.
15. **Grievances; Discharge.** The Patient retains the right to file a grievance with the Center, the long-term care ombudsman, or any regulatory agency. Nothing in this Agreement prohibits or discourages the Patient from communicating with any federal, state or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees and representatives of the long-term care ombudsman. This Agreement does not apply to regulatory appeals of an involuntarily discharge of the Patient from the Center.

## INTRODUCTION TO OUR VOLUNTARY ARBITRATION PROGRAM

The staff at the Center looks forward to being a part of your health care team and desires to provide you with a positive experience that furthers your health care goals. If you have concerns, please discuss them with the Administrator, the Director of Nursing, or any member of the staff. If you do not receive a satisfactory answer or if you desire anonymity, you may call or email the Care Line.

In the unlikely event that we are unable to resolve your concerns to your satisfaction, this Center offers a voluntary arbitration program for resolving disagreements. Here are a few highlights of the program:

- Arbitration is a process for resolving disputes using a neutral person, called an “arbitrator,” instead of litigation before a judge or jury.
- Each party has an equal say in choosing who will arbitrate the case. Experienced lawyers or retired judges are typically selected.
- The United States Supreme Court has recognized that arbitration is usually faster and more efficient than courthouse litigation.
- Arbitration is less formal than litigation and will usually take place in a conference room rather than a courtroom.
- The arbitration proceedings and records are confidential, meaning that members of the public have no access to personal medical information.
- Either side may be represented by an attorney of their own choosing or may elect not to use a lawyer at all.
- **By agreeing to arbitrate, both sides forego the right to have a judge or jury decide any dispute.**
- **The Arbitration Agreement does not need to be signed in order for the Patient to be admitted to the Center or to continue to receive care at the Center.**
- The Arbitration Agreement may be revoked in writing by certified mail at any time within thirty days after signing. Revocation will not affect the care the Patient receives.
- Please read the attached Arbitration Agreement, and if you agree, please sign where indicated.

## **GRIEVANCE PROCEDURE**

We are committed to meeting your health care needs. Most of your questions or concerns regarding patient care, services or privacy can be quickly answered by our management team at this center.

1. Discuss your question or concern with the appropriate supervisor at the center. Feel free to ask the receptionist or office staff at this center to assist you.
2. If your concern is not resolved, contact the facility Administrator or Director of Nursing.
3. If you do not receive a satisfactory answer to your question or concern or you desire to communicate on a confidential matter, please contact our corporate office by calling our toll-free number or by email. You can contact the Careline
  - a. Toll Free number at 1-800-366-1232
  - b. Email at [CareLine@ProMedica.org](mailto:CareLine@ProMedica.org)

The care line is staffed Monday through Friday, 8:00 a.m. to 4:45 p.m. (Eastern Standard Time).

## **EMERGENCY PREPAREDNESS**

The safety of our patients, guests, and employees is very important to us. As part of our commitment to caring, our team carefully monitors the situation when an emergency develops.

We are dedicated to providing patients and their loved ones with the care they deserve - even during the threat of an emergency situation.

Our employees receive emergency preparedness training during both their general orientation to the Center as well as annually. Our Center holds fire drills and disaster drills on a regular basis. Floor maps, which show Center exits, can be found posted throughout the Center.

In an emergency, family members will be advised as how they can best help Center staff. If the team determines that evacuation is necessary, the Center will notify you of the plan and the transfer location.

*Maryland*

**ProMedica Skilled Nursing  
and Rehabilitation (Wheaton)  
Center  
Supplement**



- ☐ ☐ 7. Is patient on kidney dialysis, had a kidney transplant, or covered by Medicare for End Stage Renal Disease?

If yes, date of ESRD coverage \_\_\_\_\_

- ☐ ☐ 8. Is patient currently working full or part time?

- ☐ ☐ 9. Is the patient's spouse employed and under the age of 70?

Name of person who supplied all of the above information \_\_\_\_\_

How is this person related to the patient? \_\_\_\_\_

What is this person's telephone number? \_\_\_\_\_

Date Completed \_\_\_\_\_

*This form is used to demonstrate that development for other primary payer coverage takes place. Use the quick guide reference to determine how to use the answers from the questions. It is not necessary that the completed questionnaire be signed by the patient or their representative.*

**RESIDENT TRUST FUND NOTIFICATION**

Patient's Name: William Bevan

I acknowledge that I have the right to manage my own financial affairs and that I may choose to deposit money with the Center by opening a resident trust account. If I choose to open a resident trust account, the Center will act as a fiduciary for any funds I deposit with Center and it must hold, safeguard, manage, and account for my personal funds.

☐ I decline to authorize Center to hold, safeguard, manage, and account for my personal funds.

☐ I would like to open a resident trust account which will allow me to deposit funds with the Center. I understand that I will need to sign a separate written authorization which will allow the Center to hold, safeguard, manage and account for my personal funds. The authorization will more fully explain my rights and Center's responsibilities regarding the management of the resident trust account.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Consent to Treat**

Patient's Name: William Bevan

I consent to allow the Center to:

- Use and disclose my health information for purposes of treatment, payment, or health care operations;
- Treat me to maintain my well-being; and
- Photograph me for identification purposes.

\_\_\_\_\_  
Signature of Resident or Resident's Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

2023 RATES



## *Understanding Skilled Nursing Medicare Benefits*

Medicare offers an opportunity to receive quality health care for a wide range of conditions. Many patients of ProMedica centers are eligible for Medicare so this flyer was developed to help you understand this often confusing topic for a skilled nursing facility stay\*.

### **WHAT IS MEDICARE?**

Medicare is our national health insurance program. Social Security recipients over the age of 65 or those who are permanently disabled are eligible for Medicare coverage. Medicare is similar to the coverage provided by private insurance companies. It pays a portion of the cost of your medical care and may require co-insurance or deductibles. It is not a welfare program and should not be confused with Medicaid.

### **WHAT IS THE DIFFERENCE BETWEEN MEDICARE PART A AND PART B?**

Medicare Part A covers inpatient hospital care, hospice care, inpatient care in a skilled nursing facility and some home health care services. Part B covers medical care and services provided by doctors and other medical practitioners, some home health care, durable medical equipment and some outpatient care and home health services.

### **WHAT IS COVERED BY MEDICARE?**

Medicare can help pay for these items within our skilled nursing and rehabilitation centers:

- Semi-private room.
- All meals, including special diets.
- Use of items such as braces, splints and adaptive equipment.
- Medical supplies.
- Nursing care.
- Rehabilitation services including physical, occupational and speech therapies.

### **WHAT IS NOT COVERED BY MEDICARE?**

- Private-duty nurse.
- Barber and beautician services.
- Private telephone and television.
- Long-term or permanent residency stay.



[promedicaskillednursing.org](http://promedicaskillednursing.org)

A summary of these more stringent state laws is available in the State Law Addendum. For a copy of the State law Addendum to this Notice, please contact your local Administrator or visit our Website.

#### **YOUR HEALTH INFORMATION RIGHTS**

You have the following rights regarding your health information. You may exercise these rights by submitting a request in writing to our Administrator.

**RIGHT TO REQUEST RESTRICTIONS.** You have the right to request restrictions on our use or disclosure of your health information for treatment, payment or health care operations. You also have the right to restrict the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care. Such requests should be made in writing on a form provided by us.

Although we will consider your requests with regard to the use of your health information, please be aware that we are under no obligation to accept it, except we must agree not to disclose your health information to your health plan if the disclosure (1) is for payment or health care operations and is not otherwise required by law and (2) relates to a health care item or service which you paid for in full out of pocket. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

**RIGHT OF ACCESS TO HEALTH INFORMATION.** You have the right to inspect and obtain a copy of your medical or billing records or other written information that may be used to make decisions about your care, subject to some limited exceptions. Such records will be provided to you in the time frames established by law.

We may deny your request to inspect or receive copies in certain limited circumstances. If you are denied access to health information, in some cases you will have a right to request review of the denial.

**RIGHT TO REQUEST AMENDMENT.** If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment.

We may deny your request for amendment in certain circumstances. If we deny your request for amendment, we will give you a written denial including the reasons for the denial. You have the right to submit a written statement disagreeing with the denial.

To request an accounting of disclosures, you must submit request in writing, stating a time period that is within six years from the date of your request. An accounting will include, requested: the disclosure date; the name of the person or that received the information and address, if known; a brief description of the information disclosed; a brief statement of purpose of the disclosure or a copy of the authorization or certain summary information concerning multiple similar disclosures. The first accounting provided within a 12-month period will be free; for further requests, we may charge you your costs.

**RIGHT TO A PAPER COPY OF THIS NOTICE.** You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate reasonable requests.

**RIGHT TO REVOKE AUTHORIZATION.** You may revoke your authorization to use or disclose health information, except to the extent that action has already been taken. This request must be made in writing.

**RIGHT TO BREACH NOTIFICATION.** You have the right to be notified if you are affected by a breach of Unsecured Protected Health Information.

**RIGHT TO OPT OUT OF FUNDRAISING COMMUNICATIONS.** We may contact you for fundraising purposes. You have the right to opt out of receiving these communications.

#### **FOR MORE INFORMATION OR TO REPORT A PROBLEM**

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office for Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with us, you may contact the local Administrator or call or email the Care Line at 1.800.366.1232 or careline@promedica.org.

We will not retaliate against you if you file a complaint.

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the local Administrator or call or email the Care Line at 1.800.366.1232, careline@promedica.org.

**Effective Date: September 1, 2021**

- Request that we not use or disclose your health information in certain ways;
- Request to receive communications in an alternative manner or location;
- Request access and obtain a copy of your health information;
- Request an amendment to your health information; and
- Request an accounting of disclosures of your health information.

We reserve the right to change our privacy practices and to make the new provisions effective for all health information we maintain. Should our privacy practices change, we will post the changes in a physical place within our building (if applicable) and on our website ("Website") [promedicaseniorcare.org](http://promedicaseniorcare.org). A copy of the revised Notice will be available after the effective date of the changes upon request. You may request a copy from the local Administrator/Executive Director ("Administrator") or obtain a copy on our Website.

We will not use or disclose your health information without your authorization, except as described in this Notice.

**If you have questions and would like additional information, please contact the local Administrator or call or email the Care Line at 1.800.366.1232, [careline@promedica.org](mailto:careline@promedica.org).**

#### **UNDERSTANDING YOUR HEALTH RECORD**

Each time you visit a medical provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves the following purposes:

- Basis for planning your care and treatment
- Communication among health professionals involved in your care
- Legal document describing the care you received
- Proof that services billed were actually provided
- A tool to educate health professionals
- A source of data for medical research
- A source of information for public health officials who oversee the delivery of health care
- A tool to measure and improve the care we give

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Understand who, what, when, where, and why others may access your health information
- Make informed decisions when authorizing disclosure to others

#### **HOW WE WILL USE OR DISCLOSE YOUR HEALTH INFORMATION**

##### **Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object**

**FOR TREATMENT.** We may use and disclose your health information to provide you with treatment and services. We may disclose your health information to those persons who may be involved in your care, such as physicians, nurses, aides, physical therapists, dietary and admissions personnel. For example, a nurse caring for you will report any change in your condition to your physician. While not required under federal law, we generally obtain your consent to disclose your health information for treatment purposes through our admission/enrollment process.

**FOR PAYMENT.** We may use and disclose your health information so that we can bill and receive payment for the treatment and services you receive. For example, we may use your health information to your responsible party, an insurer or managed care company, Medicare, Medicaid or another party payer. We may contact Medicare or your health plan to confirm your coverage or to request prior approval for a particular treatment or service. While not required under federal law, we generally obtain your consent to disclose your health information for payment purposes through our admission or enrollment process.

**FOR HEALTH CARE OPERATIONS.** We may use and disclose your health information for our regular health operations. These uses and disclosures are necessary to manage our operations and to monitor our quality of care. For example, we may use your health information to evaluate our services, including the performance of our staff. While not required under federal law, we generally obtain your consent to disclose your health information for health care operations purposes through our admission or enrollment process.

**ORGANIZED HEALTH CARE ARRANGEMENTS.** ProMe Senior Care participates in Organized Health Care Arrangements ("OHCA"), which are arrangements that allow ProMedica Senior Care and other participating Covered Entities to share health information about their patients to promote the joint operation of the OHCA. These joint operations include, for example, providing, monitoring, and obtaining payment for treatment in a clinically integrated care setting and working with Account Care Organizations to coordinate, assess, and improve the care provided to patients across participating entities.

**BUSINESS ASSOCIATES.** Outside people and entities provide

# Appendix

## Understanding Medicare

Medicare is a health insurance program for people 65 or older or people under 65 with certain disabilities or end-stage renal disease. Medicare doesn't cover all expenses and is not designed to pay for long-term custodial care so it's important to understand the program.

Medicare Part A helps pay for hospital stays, skilled nursing facility care, home health care and hospice care. Medicare helps pay for some skilled nursing care costs such as a semi-private room, meals, skilled nursing and rehabilitative services and other services and supplies for a skilled nursing stay after a related three-day inpatient hospital visit. Medicare pays for 100 percent of days 1 - 20 of a qualifying skilled nursing stay, but there is a co-insurance charge for days 21 through 100.

Medicare Part B helps pay for doctors' services and outpatient care as well as some services such as physical, occupational and speech therapies, some home health care and services and supplies that are medically necessary.

Many patients in a skilled nursing center receive some therapy services that may be covered by Medicare Part B. Once these services are no longer medically necessary, based on Medicare's criteria, the patient will be discharged from therapy services. Patients have a right to appeal this decision. Our team can help patients understand their options for continuing or discontinuing their therapy services.

Medicare Part C is Medicare's managed care benefit. A beneficiary may enroll in a Medicare Advantage plan and receive Medicare benefits through that plan. Different rules may apply from traditional Medicare.

Medicare Part D is the Medicare prescription drug coverage. It provides coverage for your prescription drug costs. The cost and coverage varies by plan. You must choose a plan to receive this coverage. If you have limited income and resources, you may get this coverage for little or no cost.

Medicare's premium, deductible and co-insurance amounts change each year. Our admissions team can review the current rates with you or you can visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (633-4227) for more information.

## Understanding Medicaid

The Medicaid program provides medical benefits to low-income individuals who have no medical insurance or inadequate

All states provide long-term care services for individuals who are Medicaid eligible and qualify for institutional care. Our admissions team will explain whether this center has Medicaid certification, review the state's eligibility guidelines and help you understand the Medicaid requirements.

## Medicare and Medicaid Refunds

If you are approved for Medicare or Medicaid after you are admitted to Center, you may be entitled to a refund. We will refund to you any payments you made for services and supplies that are later paid for by Medicare or Medicaid, less any deductible or share of cost. Please contact our Business Office for more information or to process a refund.

## Privacy Act Statement – Health Care Records

**1. Authority for collection of information, including social security number and whether disclosure is mandatory or voluntary.** Authority for maintenance of the system is granted under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of this information to federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These disclosures are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

**2. Principal purposes of the system for which information is intended to be used.** The primary purpose of the system

you want to receive should you be unable to communicate your wishes. You have the right to make an advance directive, such as a living will or durable power of attorney for health care. Please provide a copy of any advance directives that you may have so that we can properly carry out your wishes. If you would like more information about advance directives, please contact our Social Services Department.

#### **RESIDENT REPRESENTATIVE**

You may designate an individual to act as your representative. Your representative should be familiar with your wishes and preferences. Your representative can support you in decision-making, access your personal and medical information, manage financial matters, and receive notification.

The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

If you would like to designate a representative or for more information, please contact our Social Services Department.

#### **YOUR ROOM**

We will make every effort to provide you with the type of room that you desire.

You have the right to share a room with your roommate of choice when practicable, including sharing a room with your spouse when married residents live in the same facility. While we try to avoid frequent room changes, there may be a time during your stay when we will ask you to change your room to another location within the center. We will notify you in advance of any room or roommate changes and appreciate your cooperation as we try to accommodate the medical and social compatibility of all of our patients.

#### **PRIVACY**

Your privacy is important to us and we are committed to protecting your medical information. Our Notice of Information Practices and The Privacy Act Notification are included in the Appendix. These two documents explain how we must protect your information and our duty to collect and submit health care information to the government for Medicare and Medicaid purposes. If you have a concern about patient privacy, please contact our Administrator.

#### **THE RESIDENT/FAMILY COUNCIL**

The Resident/Family Council promotes active patient/family involvement in the center. This is a self-governing group created to present questions and suggestions to administration and staff. Our Social Services or Activity Director will be happy to provide you with meeting information.

#### **LEAVES**

Before leaving the premises, please sign-out at your respective

#### **BEDHOLDS**

If you are away from the center for more than twenty-four hours, arrangements can be made to pay for a bedhold to reserve your bed and retain your belongings at the center. If a bedhold is arranged, your bed will be held and you will be charged room and board rate until you advise us to discontinue the bedhold. Medicare does not pay for any bedholds, so Medicare patients must make arrangements to pay privately. For Medicaid patients, many states offer automatic, short term bedholds. Our admission team will discuss your state's specific policy.

If you have a bedhold, you will be readmitted to the center according to the center's policies and procedures unless the center can no longer appropriately care for you. If you return to the center, you will return to your previous room and bed unless your condition requires a transfer to another unit to receive necessary care.

If you return to the center without a bedhold, you will be readmitted to the center to the first appropriate available bed provided the center is able to properly care for you and according to the center's policies and procedures.

#### **DISCHARGE POLICY**

We may discharge you from the center if we cannot meet your needs, you no longer need our services, the health and safety of others is endangered, you fail to pay or we cease to operate.

#### **YOUR RETURN HOME**

If your goal is to return home or to a lower level of care, our Social Services team will help plan for your discharge.

## **Thank you**

Thank you again for choosing our skilled nursing and rehabilitation center. Our goal is to make your stay as successful and comfortable as possible. If there is anything we can do to improve your stay, please don't hesitate to let us know.

## Your Plan of Care

Your person-centered plan of care is a document that spells out your goals of care and how you and your healthcare team plan to accomplish those goals.

Depending on your needs, your plan of care may include:

- what kind of services you need
- what type of staff should provide those services
- how often you need those services
- what kind of equipment or supplies you need
- what kind of diet you need and your food preferences
- your health and personal goals
- how your plan of care will help you reach your goals
- information on your goals for discharge and a plan to help you meet those goals

You will help to create your plan of care with your healthcare team around the time of admission to our center. You may help to establish your expected goals and outcomes of care along with any factors related to the effectiveness of your plan of care.

You will be informed, in advance, of any changes to your plan of care. You may request to see your plan of care at any time and may sign it, if you wish, after significant changes are made.

Throughout your stay, your healthcare team will assist you with planning an efficient and effective discharge plan. The goal is to create a plan for a smooth transition to your desired location.

## Information for Your Family and Friends

### VISITORS

Visitors are always welcome in our center and we encourage visits by your family and friends.

- You have the right to receive visitors of your choosing at the time of your choosing, subject to your right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. The center may restrict or limit visitation for clinical or safety management.
- Visitors should not visit if they have a cold, respiratory symptoms, or another contagious illness.
- Children are welcome to visit but must be accompanied by an adult.
- Visitors may obtain a dinner tray to share a meal with you. The center will charge you current cost. Please notify the center in advance.

## Your Personal Items and Valuables

To make your stay more enjoyable, we have compiled a list of items that you should bring to the center and items that should be left at home. All items that you bring to the center should be clearly marked with the patient's name on them.

### WHAT TO BRING:

- Comfortable clothing and shoes
- Adaptive equipment (walkers, canes)
- Hearing aids
- Glasses
- Personal care items

Radios, televisions and other electrical items need to be inspected by our maintenance staff prior to use. Space heaters, microwaves, and extension cords (including multiple adapters or power strips) are not allowed in patient rooms under NPFA Life Safety Code.

### WHAT TO LEAVE AT HOME:

- Large amounts of money
- Valuables
- Purses/wallets
- Jewelry
- Harmful or illegal objects

### REMOVAL OF BELONGINGS AFTER DISCHARGE

Any personal belongings left at the center after your discharge should be removed as soon as possible. We will dispose of items not removed within thirty days of discharge.

### SMOKING

We believe in providing a healthy environment for you. Our center is designated as "smoke-free." Smoking is not permitted on campus or may be permitted in designated areas only. Smoking materials, including lighters, matches, cigarettes, and cigars, should be stored at the nurses' station.

### ALCOHOLIC BEVERAGES

Patients may consume alcoholic beverages in accordance with the center's policy and with physician approval. Alcoholic beverages brought into the center must be stored at the nurses' station and dispensed by the nursing staff in accordance with physician orders.

## Services

### BEAUTY AND BARBER

Beauty and barber services are available by appointment at an additional charge. Please notify us to schedule an appointment and to obtain a list of services and prices.

**SKILLED NURSING AND REHABILITATION CENTERS  
PATIENT INFORMATION HANDBOOK**

# Welcome!

Thank you for choosing our center. You made a very important decision about your health. While you are here, we hope to provide the health care services you need in a comfortable, pleasant and safe environment.

This handbook is designed to help you understand our center, services and people.

Our employees are dedicated to making your stay as welcoming and positive as possible. Please feel free to ask any of us for assistance.

Again, welcome and thank you for choosing us.

**EXHIBIT 6****PHYSICIANS WHO PRACTICE AT THE FACILITY**

Physician's Name	Physician's Address & Phone Number
Dr. Memona Tazamal: 1500 Forest Glen Rd, Silver Spring, MD 20910 : 301-754-7000	
Dr. Merlyn Vemruy: 9801 Georgia Ave, Suite 227, Silver Spring, MD 20902 : 301-593-1900	
Dr. Oney Zuniga: 18111 Prince Philip Dr, Suite 328, Olney, MD 20832 : 301-570-3668	
Dr. Alan Segal: 1517 Hugo Cir, Silver Spring, MD 20906 : 301-460-8282	
Dr. Victor Onyejiaka: PO Box 3104, Silver Spring, MD 20918 : 410-536-4100	
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make this money available to the Resident or the Resident's agent within three banking days; and

- b. If we are the Resident's agent payee for Social Security benefits, we will promptly ask the Social Security Administration to name a new agent payee and we will transfer the Resident's money to that person.

9. In the event of the Resident's death, there are several things we must do:

- a. We will convey the Resident's personal funds and a final accounting of those funds to the person in charge of administering the Resident's estate within 30 days;
- b. We will immediately notify any government agency that paid for all or part of the Resident's care in our Facility. That agency shall have the right to assist us in determining what to do with the Resident's property;
- c. If a government agency did not pay for the Resident's care, we will immediately notify the Resident's agent or next of kin to determine what to do with the Resident's property;
- d. If we have the Resident's funds, valuables or other assets in our possession, we will hold them until the appointed Personal Representative of the Resident's estate presents a copy of the certified Letters of Administration to us, or until we receive authorization from another legal representative as established by State law;
- e. We will make reasonable attempts to locate the Resident's Personal Representative and the

Exhibit 5, Page 4

funds, valuables or other assets have been stolen or damaged. The agencies to contact in order to make a complaint are listed below:

- a. The Maryland Long-Term Care Ombudsman, for persons 65 years old or older:  
  
301 West Preston Street  
Baltimore, MD 21201  
(410) 767-1100 - (800)243-3425 or  
(410) 767-1083 (for the hearing impaired)  
(410) 333-7943 (Facsimile)
- b. The local Department of Social Services for persons of any age:  
  
{FACILITY: Please Provide Address & Phone #}
- c. The Office of Health Care Quality, regardless of the Resident's age:  
7120 Samuel Morse Drive  
Second Floor  
Columbia, Maryland 21046  
(410) 402-8108 - (877)402-8219  
(410) 735-2258 (for the hearing impaired)  
(410) 402-8234 (Facsimile)

**B. Our Responsibilities**

1. We will provide a reasonable amount of secure space for you to keep the Resident's clothing and other personal property. We must investigate any damage to or loss of the Resident's personal property.
2. If the Resident wants us to manage \$50.00 or less of the Resident's personal funds, we will deposit this money in a non-interest bearing account or a petty cash fund.

<b><u>Item or Service</u></b>	<b><u>Charge</u></b>
Social Events and Entertainment Outside the Scope of the Facility's Activities Program;	Per fee
Specially-Prepared or Alternative Food Requested Instead of Food Generally Prepared by the Facility;	Per fee
Speech Therapy Services*;	Services starting at \$15.00
Telephone;	N/A
Television;	N/A
Transportation by ambulance to a physician's office.	Per fee

Exhibit 4, Page 4

community based care. Community alternatives to nursing facility services are available. Information about community alternatives can be obtained from your Local Health Department, Geriatric Evaluations Services and from your local Area Agency on Aging Office.

If you want additional information regarding Medical Assistance nursing facility benefits, please do not hesitate to call (410)767-1712 and ask for the Nursing Facility Program Specialist.

Exhibit 3B, Page 2

	MEDICARE	MEDICAID
		portions of your income as well.
HOW TO APPLY	Contact the local Social Security Office at the following address and phone number:	Contact the local Department of Social Services at the following address and phone number:
WHO TO CONTACT IF YOU HAVE A QUESTION OR A PROBLEM	To learn more about Medicare coverage of nursing home expenses, and about how to appeal a Medicare denial of payment, contact Beneficiary Relations of the Centers for Medicare and Medicaid Services (CMS) at 1-800-633-4227 or call the Senior Information and Assistance Program in your county.	If your application for Medicaid is denied, your coverage is terminated, or a service is not covered, you may appeal that decision according to the instructions contained in the notice provided to you.
RETROACTIVE COVERAGE	Not applicable.	The nursing home services that you received in the 3 months prior to your application for Medicaid may be covered by Medicaid, if you specifically request this coverage.

Exhibit 3A, Page 5

	MEDICARE	MEDICAID
		<p>a. Your house if your spouse or dependent relative lives there or if you express an intent to return there;</p> <p>b. Household goods;</p> <p>c. Personal property in your possession in the nursing home;</p> <p>d. A certain amount of money for burial arrangements.</p> <p>The value of other assets transferred within 36 months of your application for Medicaid may be considered as available to pay for your care at the Facility.</p> <p>1. <u>Income</u>: You should contact the local Dept. of Social Services to find out whether your income makes you eligible. That phone number is listed on the next page. If you qualify, \$40 per month of your income is protected for your</p>

Exhibit 3A, Page 3

**EXHIBIT 3A**  
**HOW TO APPLY FOR AND USE MEDICARE AND MEDICAID BENEFITS**

The chart below summarizes the Medicare and Medicaid programs. It also tells you who to call for more detailed information. If you have questions, our staff will also help you.

	MEDICARE	MEDICAID
WHAT'S COVERED	<ol style="list-style-type: none"> <li>1. Care in a hospital;</li> <li>2. If you are admitted to an approved facility within thirty (30) days following a three-day qualifying hospital stay (not including the day of discharge) Medicare may cover up to 100 days of skilled nursing and rehabilitation care. This coverage depends on your medical condition, and whether your doctor orders the care on a daily basis (not including weekends). If these conditions are met, Medicare provides full coverage for the first 20 days. You must make a copayment after that. The following services are examples of skilled care: <ol style="list-style-type: none"> <li>a. Injections &amp; feedings given through an IV;</li> <li>b. Tube feedings;</li> <li>c. Application of a dressing that involves prescription medication;</li> <li>d. Treatment of pressure ulcers;</li> </ol> </li> <li>3. Dietary services;</li> <li>4. Activities program;</li> <li>5. Room/Bed maintenance services;</li> <li>6. Routine personal hygiene items;</li> <li>7. Medically-related social services;</li> <li>8. Rehabilitation based on physician orders;</li> </ol>	<p>Medicaid is a comprehensive program that will cover most of the costs of a nursing home stay.</p>

Exhibit 3A, Page 1

Description of Items & Services Not Included in the Daily Rate	Charge
○ Speech Therapy All other CPT Codes	\$50.00 per 15 minute unit
○ Adult Day Care	Per fee
○ Ambulance Services	Per fee
○ Bed Specialized Rental Daily	Per vendor
○ Behavioral Health Sitter Services	Per fee
○ Cont Positive Airway Press CPAP Dly	\$.35 minimum per day
○ COVID Vaccine Administration	\$50.00 per vaccine
○ Dental Services	Per fee
○ Dialysis Service	Per fee
○ EKG, EEG and Telemetry Services	Per fee
○ Flu Vaccine	\$25.00 minimum per vaccine
○ Flu Vaccine Administration	\$40.00 per vaccine
○ Isolation Room	\$50.00 minimum per day
○ Level 1 Bariatric 1 or 2 Accessories	\$28.00 minimum per day
○ Level 2 Bariatric - 3 or more Accessories	\$55.00 minimum per day
○ L3 - Bari Bed / PR Matt + up to 2 Acc	\$126.00 minimum per day
○ L4- Bari Bed / PR Matt + 3 or more Acc	\$153.00 minimum per day
○ L5- Bari Bed / SP Matt + up to 2 Acc	\$148.00 minimum per day
○ L6- Bari Bed / SP Matt + 3 or more Acc	\$175.00 minimum per day

Exhibit 2, Page 9

Description of Items & Services Not Included in the Daily Rate	Charge
○ Occupational Therapy Neg Pres Wnd Therapy Disp Non-DME < or = to 50 sq cm	\$325.00 per 15 minute unit
○ Occupational Therapy Neg Pres Wnd Therapy Disp Non-DME- >50 sq cm	\$325.00 per 15 minute unit
○ Occupational Therapy PS WND 51CM OR MORE	\$125.00 per 15 minute unit
○ Occupational Therapy – Routine	\$15.00 per 15 minute unit
○ Occupational Therapy WND 20 CM OR LESS	\$125.00 per 15 minute unit
○ Occupational Therapy All other CPT Codes	\$50.00 per 15 minute unit
○ Physical Therapy Eval	\$125.00 per 20-45 minute unit
○ Physical Therapy Low Frequency Non-Thermal US	\$325.00 per 15 minute unit
○ Physical Therapy Neg Pres Wnd Therapy Disp Non-DME- <50 sq cm	\$325.00 per 15 minute unit
○ Physical Therapy Neg Pres Wnd Therapy Disp Non-DME- >50 sq cm	\$325.00 per 15 minute unit
○ Physical Therapy PS WND 51 CM OR MORE	\$125.00 per 15 minute unit
○ Physical Therapy Re-Eval Est Plan Care	\$125.00 per 15 minute unit
○ Physical Therapy – Routine	\$15.00 per 15 minute unit
○ Physical Therapy Unna Boot	\$125.00 per 15 minute unit
○ Physical Therapy WND 20CM OR LESS	\$125.00 per 15 minute unit

Exhibit 2, Page 7

<b>Description of Items &amp; Services Not Included in the Daily Rate</b>	<b>Charge</b>
Laboratory (Billed by the Laboratory; call (301) 942-2500 for charges)	Per vendor
Oxygen Therapy* <ul style="list-style-type: none"> <li>• Oxygen Bundle Daily (Concentrators, tanks, liquid oxygen, nasal bi-pap, portable O2 stroller, compressor and related supplies)</li> </ul>	\$11.00 minimum Daily fee
Pharmacy (Billed by the Pharmacy; call (301) 942-2500 for charges)	Per vendor
Radiology (x-ray services) (Billed by the Radiologist; call (301) 942-2500 for charges)	Per vendor
Rental Fees: <ul style="list-style-type: none"> <li>• Adult Transmitter Rental Daily</li> <li>• Cont Pass Motion (CPM) Rental Daily</li> <li>• Heelzup Thrptc Heel Elvat Cush</li> <li>• SCD Compression System Rent Daily</li> <li>• walker;</li> <li>• geriatric chair;</li> <li>• wheelchair;               <ul style="list-style-type: none"> <li>○ Wheelchair Geri Chair Rental Daily</li> <li>○ Wheelchair Standard Rental Daily</li> </ul> </li> <li>• pressure mattress;               <ul style="list-style-type: none"> <li>○ Level 1 APM Mattress and Pump Daily</li> </ul> </li> </ul>	\$1.00 minimum per day \$35.00 minimum per day \$1.50 minimum per day \$10.00 minimum per day  \$.50 minimum per day \$.50 minimum per day \$.50 minimum per day \$17.00 minimum per day

Exhibit 2, Page 5

Description of Items & Services Not Included in the Daily Rate	Charge
<ul style="list-style-type: none"> <li>Wound Vacuum – Two Wounds</li> </ul>	\$176.00 minimum per day
<p>Feeding: hand, tube*, special diet</p> <ul style="list-style-type: none"> <li>Tube Feeding Change</li> <li>Supplemental Feeding (Oral) - Glucerna Shake 8oz Can</li> <li>Supplemental Feeding (Oral) - Suplena with Carb Steady 8 oz Can</li> <li>Supplemental Feeding (Oral) Nepro with Carb Steady 8 oz Can</li> <li>Supplemental Feeding (Oral) Juven per packet</li> <li>Supplemental Feeding (Oral) Prosource Plus 1oz</li> <li>Supplemental Feeding (Oral) Prosource No Carb 1oz</li> <li>Supplemental Feeding (Oral) Prosource TF per packet</li> <li>Supplemental Feeding (Oral) Prosource ZAC 1oz</li> <li>Supplemental Feeding (Oral) Gelatein 4 oz</li> </ul>	<p>\$5.50 minimum per change</p> <p>\$1.56 minimum per serving</p> <p>\$3.70 minimum per serving</p> <p>\$3.50 minimum per serving</p> <p>\$8.52 Per 2 packets</p> <p>\$1.00 minimum per serving</p> <p>\$1.00 minimum per serving</p> <p>\$1.70 minimum per serving</p> <p>\$1.80 minimum per serving</p> <p>\$2.40 minimum per serving</p>

Exhibit 2, Page 3

**EXHIBIT 2****FOR PRIVATE PAY RESIDENTS****A. Items and Services Included in the Daily Rate.**

The items and services included in the daily rate, and their related charges, are listed below:

Description of Items & Services Included In The Daily Rate*	
1.	Room
2.	Board
3.	Social Services
4.	Nursing care, including: <ol style="list-style-type: none"> <li>The administration of prescribed medications and provision of treatments and diet;</li> <li>The provision of care to prevent skin breakdown, bedsores and deformities;</li> <li>The provision of care to keep the resident comfortable, clean and well-groomed;</li> <li>The provision of care to protect the resident from accident, injury and infection;</li> <li>The provision of care necessary to encourage, assist and train the resident in self-care and group activities.</li> </ol>
5.	Other:

\* Revise this list to accurately reflect those items and services included in the Facility's Daily Rate.

**B. Items and Services Not Included in the Daily Rate.**

Exhibit 2, Page 1

7. In the event that the Resident is involuntarily discharged from this Facility, and if other arrangements cannot be made, do you agree to accept the Resident into your custody, if it is medically and legally appropriate?  
Yes \_\_\_\_\_/No \_\_\_\_\_ Initials \_\_\_\_\_

### **RIGHTS OF THE AGENT**

- F. YOU HAVE THE RIGHT TO COPIES OF THE FOLLOWING DOCUMENTS. I ACKNOWLEDGE RECEIPT OF THE FOLLOWING DOCUMENTS:

1. A copy of this Admission Contract;
2. The Facility Handbook (where applicable);
3. A copy of Federal and State Residents' Rights;
4. A list of the Facility's charges, including the charges not included in the per diem rate;
5. A list of health care providers offering services at the facility and their current charges; and
6. Others:

Initials \_\_\_\_\_

THE DOCUMENTS IN F.1 THROUGH F.6 MAY BE AMENDED FROM TIME-TO-TIME CONSISTENT WITH STATE AND FEDERAL LAW AND REGULATIONS. WHEN AMENDMENTS ARE MADE, YOU WILL BE PROVIDED A COPY.

- G. YOU HAVE THE RIGHT TO BE NOTIFIED BY THE FACILITY OF ANY EVENT OR OCCURRENCE INVOLVING THE RESIDENT WHICH DIRECTLY AFFECTS YOUR OBLIGATION UNDER THIS AGREEMENT.

my own funds. "Abuse of funds" means using the assets or income of a Resident against the express wishes of the Resident unless the expenditure was necessary for the direct and immediate welfare of the Resident. Abuse also means using the assets or income of the Resident for the use or benefit of another unless such use is for the direct and immediate benefit of the Resident or is consistent with an express wish and past behavior of the Resident.

- E. IN ORDER TO PROPERLY PLAN FOR THE RESIDENT'S NEEDS, IT IS IMPORTANT THAT WE HAVE THE ANSWERS TO THE FOLLOWING QUESTIONS. PLEASE INDICATE "YES" OR "NO" TO EACH AND INITIAL. YOU ARE NOT REQUIRED TO ANSWER "YES" AND AGREE TO ASSUME RESPONSIBILITY FOR THE ISSUES ADDRESSED IN E.1. - E.7 (THESE OBLIGATIONS ARE NOT REQUIRED FOR THE RESIDENT'S ADMISSION); HOWEVER, YOU MAY VOLUNTARILY ANSWER "YES" AND AGREE TO ASSUME ANY OR ALL OF THE FOLLOWING:

1. Do you knowingly and voluntarily agree to make payments required under this Agreement from YOUR OWN RESOURCES?  
Yes \_\_\_\_/No \_\_\_\_ Initials \_\_\_\_\_
2. Do you agree that in the event of the Resident's death, you shall take responsibility for all burial arrangements for the Resident and for removal of all of the Resident's personal property from the Facility, subject to your legal authority to accept the property:  
Yes \_\_\_\_/No \_\_\_\_ Initials \_\_\_\_\_
3. In the event you are not able to remove the Resident's personal property promptly and, consequently, the Facility is unable to admit another Resident to the deceased Resident's room, do you agree to:

Exhibit 1, Page 5

- \_\_\_\_\_ 1. I agree to pay the Facility bill in a timely manner to the extent that the Resident has income, funds and/or assets to pay for such services.
- \_\_\_\_\_ 2. In the event the Resident is a beneficiary of Medicare, Medicaid, or any other third-party payment plan, I agree to pay all co-payments, co-insurance and deductibles, and all charges for non-covered items and services, together with any applicable late fees, to the extent of the Resident's income, funds and/or assets.
- \_\_\_\_\_ 3. In the event I have not paid a current bill to the Facility for the Resident's care, I agree to apply to Medical Assistance for a determination of the funds available to pay for the cost of the Resident's care.

(NOTE: I understand if I fail to seek this determination, the Facility will seek a Court Order requiring me to do so.)

- \_\_\_\_\_ 4. In the event the Resident's private income, funds and assets are exhausted during the Resident's stay, I agree to apply for and pursue with diligence Medical Assistance benefits for the Resident in a timely manner, and to cooperate fully in the eligibility process.
- \_\_\_\_\_ 5. I agree to apply for Medicare, Veterans Administration or other third-party benefits which may be available to cover the cost of the Resident's care at the Facility.
- \_\_\_\_\_ 6. In the event the Resident is applying for admission on a private pay basis, I agree to assist the Resident in providing financial information required by the Facility to determine the extent of the Resident's income, funds and/or assets.

## **EXHIBIT 1 OBLIGATIONS OF THE AGENT**

Only an Agent may sign this Agreement. An Agent is an individual who manages, uses or controls a Resident's income, funds and assets that legally may be used to pay for the care or services that a Resident receives from a nursing facility. An Agent is obligated to use the Resident's income, funds and assets to pay the Facility for the Resident's care. The financial obligation of the Agent is limited to the amount of the Resident's income, funds and assets. The Agent assumes no personal liability for the Resident's stay at the Facility unless the Agent voluntarily agrees to be personally responsible for any payments required under this Contract which are not paid by the Resident or a third-party insurer. (See question E.1., below.)

A nursing facility may not require an Agent to sign the Admissions Contract unless the applicant has been adjudicated disabled by a court or the applicant's physician has certified, in writing, that the applicant is incapable of understanding or exercising his or her rights and responsibilities. However, an Agent may voluntarily agree to sign the Admissions Contract, on behalf of an incapable applicant or at the request of a capable applicant even when the above conditions are not met.

A. ONE OF THE FOLLOWING CONDITIONS MUST BE MET IN ORDER TO REQUIRE YOU AS THE AGENT TO SIGN THIS ADMISSIONS CONTRACT. (These are not required if you are signing voluntarily.)

1. Has the applicant been adjudicated disabled by a Court?  
Yes \_\_\_\_\_ or No \_\_\_\_\_
2. Has the applicant's physician certified, in writing, that the applicant is incapable of understanding or exercising his or her rights or responsibilities?  
Yes \_\_\_\_\_ or No \_\_\_\_\_

Exhibit 1, Page 1

- B. Items and Services Not Covered by the Daily Rate.

\_\_\_\_\_ Exhibit 3.

- A. How to Apply For and Use Medicare and Medicaid Benefits.
- B. Medical Assistance Nursing Facility Services (Medicaid Medical Eligibility Form)

\_\_\_\_\_ Exhibit 4. Items and Services Not Covered by Medicaid.

\_\_\_\_\_ Exhibit 5. Policies and Procedures Concerning the Resident's Personal Funds and the Resident's Personal Property.

\_\_\_\_\_ Exhibit 6. Physicians Who Practice at the Facility.

\_\_\_\_\_ Exhibit 7. Services Provided by Outside Health Care Providers.

7. Changes In Law.

Any provision of this Contract that is found to be invalid or unenforceable as a result of a change in State or Federal law will not invalidate the remaining provisions of this Contract and, it is agreed that to the extent possible, you and the Resident and the Facility will continue to fulfill their respective obligations under this Contract consistent with the law.

the Resident no longer needs the services we provide; (b) the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met by the Facility; (c) the health or safety an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay, or through the Resident's insurers have failed to pay, for a stay at the Facility; or (e) the Facility ceases to operate.

If we decide that the Resident should be transferred or discharged for one of these reasons, we will notify the Resident and you, the Resident's family member, guardian or representative, by letter 30 days in advance. We will also notify the Office of Health Care Quality and the Maryland Long-Term Care Ombudsman. If the Resident is transferred because of an emergency situation, we will provide the required notice as soon as practicable. The involuntary discharge letter will contain the reasons for the transfer or discharge and its effective date, the name of the staff person responsible for the Resident's discharge planning services, a proposed date for a discharge planning meeting, and the Resident's rights regarding discharge or transfer. The letter will also tell the Resident and you how to appeal our decision to transfer or discharge the Resident, by requesting a hearing, and will tell you what agencies may assist you.

If the Resident is to be discharged involuntarily, we will comply with current law in making discharge or transfer arrangements.

You and the Resident must cooperate and assist in the discharge planning, including cooperating with and assisting other facilities considering admitting the Resident and cooperating with governmental agencies. If you or the Facility believe that an abuse of funds contributed to the transfer or discharge for non-payment, you may, or the Facility will ask the Attorney General to investigate and make referrals to other governmental agencies.

5. Right to End This Contract.

Office of Health Care Quality  
7120 Samuel Morse Drive  
Second Floor  
Columbia, MD 21046  
(410) 402-8110  
(877) 402-8219  
(800) 735-2258 (TTY)  
(410) 402-8234 (Facsimile)

State Long-Term Care Ombudsman  
301 West Preston Street  
Room 1007  
Baltimore, MD 21201  
(410) 767-1100  
(800) 243-3425  
(410) 767-1083 (TTY)

If the Facility is unable to resolve the complaint, it will be sent to the Maryland Long-Term Care Ombudsman and the Office of Health Care Quality. A hearing may be requested from that Office.

E. Holding the Resident's Bed if the Resident Leaves the Facility

Leave of Absence

If the resident is on a leave of absence from the Facility for reasons other than a hospitalization, we will hold a bed for the resident as follows:

1. Private Pay Residents:

If the resident is a private-pay resident, or are receiving inpatient care reimbursed under the Maryland Medicare Program (and the resident is not covered under Medicaid), we will hold a bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

2. Medicaid Residents:

If the resident is away from the Facility on a leave of absence which is provided for in the resident's plan of care and approved by the physician, we will hold a bed for the resident for up to the maximum number of days required under Medicaid regulations, currently 18 days each calendar year. While we are holding a bed, you are still required to pay the Facility any amount for which you are responsible as determined under the Medicaid Program.

If the resident's leave of absence exceeds the total number of

4. Resident Rights.

As a Resident of this Facility, the Resident has many rights under federal and state law. Some of those rights are listed in this section. You and the Resident will be given a written description of all of the Resident's rights.

A. The Resident's Right to Make Decisions.

The Resident has the right to make the Resident's own medical decisions, to manage the Resident's personal affairs and to access the Resident's medical records as permitted by law. If the Resident becomes incapable of making the Resident's own decisions, it may be necessary for someone else to make decisions for the Resident. For this reason, we recommend that the Resident make advance directives for medical decisions and appoint a Power of Attorney for financial decisions, but the Resident is not required to do so. It is recommended that the Resident consult with an attorney to prepare a financial Power of Attorney. As part of the admission process, you and the Resident will be given a description of the Resident's legal rights to decide about the Resident's future medical treatment, as well as information about making advance directives. If the Resident makes an advance directive, you should provide the Facility with a copy.

B. Selection of a Doctor or Other Provider.

The Resident may select the Resident's own doctor and other health care providers. The Resident's doctor and other health care providers must follow our policies.<sup>5</sup> The Resident or you on behalf of the Resident, or the Resident's insurer, including the Medicaid

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<sup>5</sup> If the Resident's doctor and other health care providers do not follow Facility policies and procedures, the Facility will ask the Resident to choose other providers.

F. Interest Penalties.

We may not charge you a penalty if you pay the Resident's itemized statement on time. Payment is on time if it is made within 45 days of the date the bill is postmarked, or 30 days after the end of the billing period, whichever is later. The interest penalty we charge is 0% of the amount due, calculated on either a ( 0 ) daily or ( 0 ) monthly basis. For any bill delinquent over one month, penalties will be calculated on either a ( 0 ) simple or ( 0 ) compound basis.<sup>4</sup>

G. Private Duty Nurses/Geriatric Aides.

If you or the Resident want a private duty nurse or a private duty geriatric aide for the Resident, you are responsible for selecting a person licensed and/or certified according to Maryland laws and regulations. You are also responsible for paying him or her, and for letting us know that you have hired one. The person you hire is not an employee or agent of the Facility, but he or she must meet our standards and follow our policies and procedures. Employees of the Facility may not serve as private duty nurses or private duty geriatric aides.

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<sup>4</sup> The Facility may not charge interest on a Medical Assistance contribution to cost of care for covered services.

not covered by Medicare, Part A, you agree to pay any required deductible, and any applicable co-insurance.

D. Medicaid Residents.

We participate in the Medicaid Program. For information on Medicaid, see Exhibit 3A. [The Exhibit is written in terms of the Resident.] The Resident is not required to give up any of the Resident's rights to Medicaid benefits to be admitted or to stay here. If the Resident's private funds are used up during the Resident's stay here and the Resident is eligible for Medicaid, we will accept Medicaid payments.

Although it is the Resident's and your responsibility to apply for and obtain Medicaid benefits for the Resident, we will assist you, by promptly providing Medical Assistance with all required information in our possession. If the Resident is eligible for Medical Assistance, the Facility may not charge, ask for, accept or receive any gift, money, donation or consideration other than Medicaid reimbursement as a condition of the Resident's admission or continued stay here.

If the Resident receives Medicaid, most of the Resident's nursing home charges such as room, board and general nursing care are covered, although Medicaid may require you to pay some amount from the Resident's monthly income. The local Department of Social Services will tell you whether you have to pay part of the charge for the Resident's care and, if so, how much. You understand and agree to pay to the Facility on a timely basis this contribution amount as determined and periodically adjusted by the local Department of Social Services. If you fail to pay this amount, we may request a court to order such payment.

A list of the items and services covered by Medicaid (which are published at COMAR 10.09.10.04) is posted in the Facility at the following location: Front Lobby at Info Desk.

You understand and agree that you are responsible for paying the Facility for items and services provided to the Resident during any period of time in which the Resident is or was a resident of the Facility and during which the Resident has not been determined eligible for Medical Assistance. If you do not pay the amount owed us after receiving Facility bills and we hire a collection agency or attorney because of your breach of this Agreement, you agree to pay their fees, expenses and court costs with your own funds.

If you do not pay what is owed the Facility, you agree to apply to Medical Assistance for a determination of the Resident's income and assets available to pay the cost of the Resident's care. Once Medical Assistance determines the income and assets available to pay for the Resident's care, you agree to use such income and assets to pay the Facility's bills.<sup>3</sup> (Your request for this determination is not the same as applying for Medical Assistance on behalf of the Resident.)

You agree to notify the Facility promptly if the Resident has insufficient income, funds, or assets to meet the Resident's financial obligations to the Facility and you agree to apply for Medical Assistance benefits in a timely manner and to cooperate fully in the Medical Assistance eligibility determination process. If you do not apply or cooperate fully in the process, the Facility may ask the court to order you to do so.

If you are no longer able to pay for the Resident's care at the Facility and the Resident is not eligible for Medical Assistance,

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<sup>3</sup> If you do not request a determination by Medical Assistance, or if payment is not made with the income and assets determined to be available for the Resident's care, the Facility may ask the court to order you to obtain the determination or to make payment. If you are willfully or grossly negligent in not paying the amount determined by Medical Assistance to be available for the Resident's care, you may have to pay a civil money penalty of at least that amount with your own money.

is not authorized by the Resident, or that is not necessary for the direct and immediate welfare of the Resident.<sup>2</sup>

You agree to provide us with all information about the Resident's finances and health. You understand that, if we later find that you knowingly provided the Facility with incomplete or inaccurate information, we will consider that a breach of this Agreement.

It is anticipated that the Resident's care will be paid for by:

- ☐ The Medicare Program;
- ☐ The Medicaid Program (also known as "Medical Assistance");
- ☐ Other third-party insurer, please specify: \_\_\_\_\_;
- ☐ You with the Resident's income, funds and/or assets;
- ☐ You with your own income, funds and/or assets;
- ☐ Other, please specify: \_\_\_\_\_.

It is understood that Medicare and Medicaid will make the determination concerning the Resident's medical and financial eligibility for payment by those programs.

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<sup>2</sup> If there is an abuse of the Resident's funds, the person who misused the funds is guilty of a misdemeanor and, on conviction, is subject to a fine up to \$10,000. "Abuse of funds" means using the assets or income of a resident against the express wishes of the resident unless the expenditure was necessary for the direct and immediate welfare of the resident. Abuse also means using the assets or income of the resident for the use or benefit of another unless such use is for the direct and immediate benefit of the resident or is consistent with an express wish and past behavior of the resident.

**Resident's Agent  
Financial Agreement With  
ProMedica Skilled Nursing and Rehabilitation (Wheaton)**

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This Contract Has Been Approved by  
The Maryland Department of Health

1. This Contract is between  
Manor Care of Wheaton MD, LLC  
DBA  
ProMedica Skilled Nursing and Rehabilitation (Wheaton)  
(the "Facility", or "we", or "us") and  
(the "Agent" or "you") because you have access to (use,  
management, or control of) the income, funds and/or assets of  
William Bevan (the "Resident") and  
because you are willing to act on behalf of the Resident. A checklist  
of the obligations and rights you have as the Resident's Agent is at  
Exhibit 1. The questions on the checklist must be answered by you  
and the checklist is incorporated into this Agreement.

2. In consideration of your payment and promises made in this  
Agreement, the Facility agrees to do the following:

**Health Care Services**

A. We will provide the Resident with general nursing care  
and nursing treatments such as administration of medication,  
preventive skin care, assistance with bathing, toileting, feeding,  
dressing and mobility. (Throughout this Agreement is information about  
which services are covered in the Facility's daily rate and which are  
available for an additional charge.)

B. When the Resident's doctor orders health care  
services which we do not have the capability to provide (with the

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